

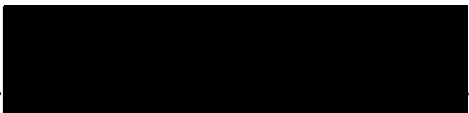
**Life Space Mapping:
Developing a visual method for
investigating the outcomes of counselling
and psychotherapy from the client's frame
of reference**

Brian Rodgers

**A thesis submitted in partial fulfilment of the requirements of the
University of Abertay Dundee for the degree of Doctor of Philosophy**

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I certify that this thesis is a true and accurate version of the thesis approved by the examiners.

Signed .. 

(Director of Studies)

Date.....5/7/10.....

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Be present... let go... with heart...

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ABSTRACT

Background: This thesis presents an investigation into the development of a new visual method for examining the outcomes of counselling and psychotherapy. The project is contextualised through a critical review of theory and research into the nature of assessment techniques for evaluating the effectiveness of counselling and psychotherapy.

Research method: The empirical study draws on the concept of research as bricolage within a social constructionist epistemology to explore participants' experiences of a multi-method approach to assessing the outcomes of therapy. In particular, a visual, creative approach implemented in terms of 'Life Space Mapping' was used to collaboratively explore the changes from therapy of 17 participants within a volunteer counselling service. This approach was complemented by the use of a standardised outcome questionnaire in the form of the CORE-OM. Interviews were conducted at pre-therapy, post-therapy and follow-up involving the construction of the LSM, completion of the CORE-OM, reflection on any change, and the participants' experience of using each method for reflecting on change. Strategies for data analysis included the use of a case study approach, presentation of a montage of visual material, thematic analysis of interview transcripts, and benchmarking of quantitative results against established norms.

Findings: The results of the study indicate that Life Space Mapping was able to access rich, in-depth narratives of change that revealed a different 'picture' of outcome than the traditional quantitative approach. Further, the study was able to reveal details of participants' experience of both methods. Both the LSM and CORE-OM were found to offer an opportunity to reflect on change, and were experienced as potentially growthful and therapeutic when used in a collaborative fashion. However, significant issues were also discovered regarding participants idiosyncratic responses to the CORE-OM.

Conclusions: The study demonstrates that the LSM provides a powerful adjunct to traditional approaches to outcome assessment which facilitates clients' reflections on change in terms of their own 'life' and their own 'space'. Further, it highlights the value of offering outcome data back to the clients themselves such that they can make use of it for their own growth processes. Additionally, the study calls into question the solidity of the existing evidence base within counselling and psychotherapy in terms of the underling data being an accurate representation of client's actual experiences, and makes the case for more 'client centric' approaches to outcomes research.

PREFACE

My initial interest in researching the client's perspective of the outcomes of therapy started as a result of my counselling training. As a trainee person-centred therapist, I was very interested in Rogers' (1957) statement of the necessary and sufficient conditions of therapeutic change. Though my training focused largely on the three 'core' conditions of empathy, congruence and unconditional positive regard, I was struck by the inclusion of the 6th therapeutic condition - that "The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved." (p. 96). I read into this statement the importance of acknowledging the necessity for the client to *perceive* all the 'core' conditions of the therapist before therapeutic change can happen – that the therapist can be as embodying of the therapeutic principles as is possible, but unless the client perceives this, then it is a waste of time. For my own research, I wanted to take this further and discover more about *how* clients perceived their therapy - what was important for them and what really made a difference in *practice* rather than just in theory.

This led me to undertake an MSc in Counselling Studies at the University of Abertay, Dundee to investigate the client's experience of therapy using in-depth qualitative interviews (Rodgers, 2002). The study involved post therapeutic interviews with clients from the same voluntary organisation as the present study. Clients were interviewed between three and four months following therapy and asked to relate what they perceived had changed from before to after counselling, what part therapy had played in these changes, and what was most important or significant in their therapy. The aim here was not to assume that therapy was the central change ingredient, or to make a direct causal link between therapy and outcome, but to find out more from the client's own perspective about their experience of therapy and the changes in their life. From this study, it was readily apparent that clients experienced therapy in a large variety of ways, some hindering, some unhelpful, and some very helpful. Further, it was clear that clients themselves were the key 'active ingredient' in the changes experienced over the duration of therapy (Bohart & Tallman, 1999).

One of the main results of the study was the finding that the process of 'restructuring' seemed to be a key outcome for clients. This was reported as "coming to see things from a different perspective, of things 'fitting' better and feeling more integrated, of being able to let go of things and of being more in control and content. It was as if things become restructured for the person such that problems and issues were resolved in one way or another." (Rodgers, 2002 p. 190)

It was this aspect of change that initially sparked the present study. I wanted to see if this dimension of change could be explored more fully, not in terms of discrete components, but more holistically. Here I was interested in seeing if this 'restructuring' outcome could actually be

captured in a way that made sense to participants, of finding a way that allowed participants to reflect on change from a more holistic, integrated perspective. What also interested me was that participants who reported this ‘restructuring’ had difficulty in fully remembering how things were before their therapy, as therapy seemed to quite fundamentally alter their perception of their life. This led to the idea of asking clients to create a ‘snap shot’ or ‘picture’ of their life before therapy began, so as to ‘capture’ this pre-therapy perception.

This initially simple idea expanded into the development of the Life Space Map (LSM). The basic concept of taking a ‘snap shot’ remains, but the LSM incorporates a shift in emphasis away from the individual in isolation, towards seeing the individual as intimately connected and situated in a complex social world. Concepts from social and ecological psychology have played a key role in this development, leading me to question counselling and psychotherapy’s apparent over emphasis on individualism, individual power, and responsibility. I have become aware of the potential paradox of therapy, that in the process of working towards empowering individuals in their predicaments, we can slip into putting the responsibility of these predicaments on the individual. In the process of helping people to overcome their difficulties, we are also saying that it is their responsibility. This potentially misses the question of whether the apparent growth in the number of people struggling to cope is a function of an unhealthy society rather than unhealthy people. Further, I feel there is a tendency to over emphasise the role of therapy in people’s change process, especially in traditional approaches to research. Rather than seeing therapy as the central or key ‘variable’ in change, it feels more realistic to frame counselling and psychotherapy as one of many resources that people can use. The present study can be seen as an attempt to construct a research instrument which parallels this view, of refocusing the outcomes of therapy in terms of the ‘life space’ of the client, and to ‘position’ counselling within this as one ‘thing’ among many.

An additional result from undertaking the original study was the discovery of how little literature there was that had attempted to investigate the client’s perspective of the outcomes of therapy at any depth. From a naïve starting point, I had assumed that there would be hundreds, if not thousands of studies that had involved in-depth exploration with clients about what they had found beneficial from attending therapy, especially within the person-centred tradition. To my great surprise, McLeod (2000b) could find only *six* published qualitative studies that had attempted to investigate the outcomes of therapy using exploratory, non quantitative methods. As a practitioner, and later as a trainer and supervisor, I found it difficult to understand the seeming lack of interest by researchers in the subtleties and nuances of outcome experienced by different people. Further, as a client myself of therapy, I just could not see the validity of reducing my own complex and interwoven experiences to a few tick marks on a sheet of paper. It felt to me like an enormous gap existed between the research of counselling and psychotherapy outcomes using traditional quantitative questionnaires and what people actually experience as ‘coming out’ of therapy. This led to my call for researchers to more actively investigate the client’s experience of the outcomes of

therapy using qualitative methods, and to find new ways of asking the *client* what was most beneficial, rather than assume our existing theoretically constructed definitions of outcome were correct (Rodgers, 2003). As such, the present study can be seen as a direct answer to this call – an attempt to ‘put my money where my mouth is’ so to speak.

An integral part of undertaking my initial study was my apprenticeship into qualitative research methods. Having studied physics, mathematics and computer science in my first degree, I was initially set on employing a quantitative approach in order to obtain ‘hard facts’. However, I was eventually persuaded by my supervisor that in order to answer the questions I was posing, I would need to adopt a richer, more ‘client near’ approach. So started my long journey of discovery into the realm of qualitative research, in particular to the ideas of Glaser and Strauss (1967) and their insistence that any ‘theory’ generated must be grounded in the data obtained. Glaser’s writing especially attracted me in his more holistic approach to the coding of data and the generation of results. In addition, more contemporary authors such as Pidgeon and Henwood (Pidgeon, 1996; Pidgeon & Henwood, 1996) and in particular Rennie (1996; 1998; 2000b) pointed me in the direction of how such an approach to research could be applied to the study of psychology and psychotherapy.

This led me deeper into the philosophical considerations of qualitative research as I attempted to locate myself in the heady world of post modern research approaches. My initial attraction to extreme relativism, with its insistence that there is no ‘truth’ other than that perceived by the ‘subject’ seemed a natural fit with my research topic. However, as I explored this further, I began to get lost in the seemingly endless philosophical debates around the nature of perception, experiencing and even of ‘being’. From initial attempts to read and comprehend Heidegger, Foucault and others, I soon realised that I was out of my depth, and turned to other contemporary researchers in the field to construct a framework of understanding. In particular, the more pragmatic approach by McLeod (2001c) of the researcher as ‘bricoleur’ seems to resonate. Here the researcher is not so much an expert artisan, but more “someone who works with his hands and uses devious means compared to those of the craftsman” where “the *bricoleur* is practical and gets the job done” (Weinstein and Weinstein, 1991 as cited in McLeod, 2001c p.119).

Along with this academic and professional journey, this study has also been deeply integrated into my personal ‘life journey’. The main theme that comes to mind when I recall this journey is around my struggle to ‘stand up and be seen’. I have really struggled in writing up this study, in particular with the literature review where I have felt I have had to ‘arm myself’ with the words of others before I can dare to ‘put my head above the parapet’. This feeling runs deeply and has been paralysing at times, resulting in the write-up stage being drawn out over 3 years! This has felt a long time to be ‘stuck’, such that at times I have felt close to giving up. Sometimes I have thought that if I were ‘stronger’, I would indeed have let go of this process, to have learnt to stand tall

without the need of prop myself up with the letters 'PhD'. On better days though, I can see this journey as a coming face to face with my fears and anxieties about being seen. This does not feel close to being a completed process, but rather one I am continually working on. In the very moment of writing this, I sense the edge of my 'comfort zone', of my anxiety about how these personal revelations will be 'seen' by others. Though definitely not comfortable, this feels like an essential growth process, of learning to slowly face my fear of being 'shot down in flames', and of meeting my anxieties rather than shying away from them.

Finally, I have also come to the realisation that this study will never be 'complete', and will definitely not be 'perfect'. There will be holes in the parapets, along with plenty of ammunition for critics to fire at me. So an ongoing process for me is learning to 'take the hit', or rather, to meet the criticism, not rigidly, but flexibly. Here the essence of learning from my Tai Chi teacher feels most relevant, the sense of meeting that which is coming at me, of reaching toward this and 'sticking' with it, connecting with it and not being afraid, not collapsing, but rather subtly yielding to deflect the power away. Here the principles of becoming aware of and attuned to the 'other', of becoming grounded and 'rooted', and of being 'full hearted' and fearless in the encounter come alive. This feels like the real 'learning' for me in this endeavour, one that is far from realised in the text of this thesis, but is there, under the surface, occasionally sending shoots of new growth out into the open. This, then, feels like my true contribution – the adding of my own unique colour and shape to the collage of the research landscape.

1 INTRODUCTION

Counselling and psychotherapy outcomes have traditionally been measured using standardised quantitative questionnaires. Though efficient for large numbers of participants, this method is not well suited to capturing the unique and subtle ‘shifts’ that clients often report when qualitative methods are utilised. Further, such questionnaires usually focus on only the psychological aspects of the individual, missing the wider social implications of therapy. Additionally, the use of words and numbers alone potentially misses the more creative, holistic, and insightful outcomes of therapy. This thesis explores the development of a new visual method for investigating the outcomes of counselling and psychotherapy from the client’s own frame of reference utilising the concept of “Life Space Mapping”.

1.1 The need for evidence – a historical perspective

The history of research into the process and outcome of therapy dates back over 80 years (Bergin, 1971). Over this time, the majority of outcome studies have been designed to demonstrate the efficacy of therapy (Lambert & Ogles, 2004), i.e. to show that therapy in general, or a particular aspect or approach to therapy, has a measurable effect. This endeavour can to some degree be seen as a response to various challenges regarding the effectiveness of counselling and psychotherapy. A classic example of this is the response to the criticism levelled at psychotherapy by Hans Eysenck in 1952 (Eysenck, 1952). His critique of the research into psychotherapy at the time stated that the evidence was “not sufficient to prove that psychoanalysis and psychotherapy was instrumental in mediating recovery” (Eysenck, 1992 p. 103). This critique sparked a plethora of research studies and meta analysis of outcome data (Strupp, 1978).

Though it would now seem that this basic challenge to the general efficacy of counselling and psychotherapy has been answered (Lambert, Bergin, & Garfield, 2004), a similar dispute has emerged regarding the efficacy of different forms or approaches to therapy. This more contemporary battle can be seen as a drive toward credibility, and even a struggle for survival, in an ever more competitive arena fenced in by funding restrictions, government regulation and health service policies (Brown, Dreis, & Nace, 1999; Rowland & Goss, 2000). In this ever tightening arena, evidence is the weapon of choice, with each contestant attempting to arm themselves with the ‘strongest’ and ‘hardest’ evidence available in order to dominate the field.

1.2 The traditional hierarchy of evidence

Little wonder, given the above scenario, that researchers have largely relied on the ‘solidity’ of natural scientific method in order to gather the evidence. This approach, so successful in the physical sciences, emphasises objectivity, repeatability, and statistical reliability when gathering data. Studies which most closely adhere to this scientific method, such as randomised controlled trials (RCTs), are generally seen as the ‘gold standard’ as far as evidence goes.



Figure 1-1 Traditional hierarchy of evidence

The diagram above illustrates the classic example of this hierarchy of evidence based on guidelines from the U.S. Preventive Services Task Force (USPSTF, 1996). Randomised controlled trials are at the top of the hierarchy, followed by non randomised trials such as case control or cohort studies, with expert opinions based on clinical experience, descriptive studies and case reports or reports of committees at the very bottom. This hierarchy of evidence provides an elegant and logical method for grading the ‘value’ of evidence. However, beneath this appealingly simple structure lies a much more complex reality. Variations in methodological approach, researcher allegiance, sampling procedures, data collection and analysis methods etc influence the outcomes reported from studies at all levels in this hierarchy. As such, recent attempts have been made to enhance this simple hierarchy with the incorporation of quality adjusters (National Institute for Health and Clinical Excellence, 2007; SIGN, 2008). This enables a high quality case control study to ‘out rank’ a lower quality RCT, and even for a very high quality case report to have significant influence. However, the basic model is intrinsically the same, with randomised trials always out ranking other individual studies of equal quality.

1.3 Evidence based practice and empirically supported treatments

Traditionally, the hierarchy of evidence discussed above has been used to construct guidelines on 'best practice'. Within the UK, the National Institute for Health and Clinical Excellence (NICE) uses a version of this hierarchy to provide "systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances" (National Institute for Health and Clinical Excellence, 2007 p. 9). Similarly, in the US the American Psychology Association has defined a set of Empirically Supported Treatments (ESTs) (Task Force on Promotion and Dissemination of Psychological Procedures, 1995; Society of Clinical Psychology, 2008) based on treatments which could be identified as being empirically supported by the research evidence to date (Chambless & Hollon, 1998; APA Presidential Task Force on Evidence-Based Practice, 2006).

This approach, often termed evidence based practice or EBP, has its origins within the medical profession where it is defined as:

the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996. p. 71).

This definition brings attention to the importance of integrating research evidence with clinical expertise, rather than relying purely on knowledge gained from clinical trials. However, within the field of counselling and psychotherapy, there is considerable debate over the appropriateness of this model for supplying guidelines on best practice.

1.4 Efficacy research versus effectiveness research

One of the central debates around evidence based practice is the differentiation between *efficacy* research and *effectiveness* research, and the tension between the internal and external validity of studies. Roth and Fonagy (2005) identify that efficacy research, with its emphasis on demonstrating that a particular therapy can be shown to be efficacious under controlled conditions, necessitates a high level of *internal validity* to ensure a causal relationship can be inferred between an

intervention and the outcome. As such, a well constructed RCT requires careful selection of participants such that they are relatively homogenous, tightly controlled, manualised interventions to ensure treatment adherence, along with psychometrically proven outcome measures, preferably from multiple sources (e.g. participant, therapist and observer), to ensure accurate, quantifiable measurement of change.

The result of this rigorous approach to the internal validity of outcome research is that therapy is undertaken in conditions which bear little resemblance to clinical practice. Kazdin (1991) points out that formal research projects and clinical practice differ in who is treated, how they are treated, how long they are treated, and the range of people involved in the treatment (researchers, observers etc). This poses a threat to the *external validity* of many research studies i.e. the extent to which the causal relationship established in the study can be inferred to apply more generally in other settings (Roth & Fonagy, 2005).

This debate over the external validity of RCTs and similar studies suggests that standards and guidelines constructed purely from efficacy research have the potential to be seen as irrelevant to the actual practice of counselling and psychotherapy (Goldfried & Wolfe, 1996; Persons & Silberschatz, 1998). On the other hand clinical effectiveness studies, which attempt to investigate the outcomes of therapy in routine practice, have a much higher external validity but make it more difficult to infer direct causal relationships between an intervention and the outcome (i.e. poor internal validity). As such, it would seem that a good balance between efficacy research and effectiveness research is required (Bower, 2003).

1.5 From psychometrics towards clinimetrics

Within the UK, the move towards a better balance between efficacy research and effectiveness research has taken the form of practice based evidence. Here, practitioners are encouraged to adopt a greater interest in collecting research within their usual practice settings, and contributing this within a research network (Barkham & Mellor-Clark, 2000, 2003). Further, such an approach can be adopted to inform practitioners as to whether or not their current treatment approach is working for a particular client. Rather than classifying a client into a particular diagnostic category and then applying a manualised treatment to them, a practice based model gives therapists a method of informing their practice from data gathered directly from their own clients (Lambert, Hansen, & Finch, 2001).

The shift in focus from evidence based practice to practice based evidence also requires a change in focus around how evidence is collected. From the viewpoint of the hierarchy of evidence, studies that gather evidence from a variety of perspectives, such as the participant, the therapist and

independent observers are most desirable (Roth & Fonagy, 2005). Such studies require measures with solid psychometric properties capable of gathering generalised data which can be compared across large groups of participants. However, from the practice based evidence perspective, the focus shifts to gathering data which has high clinical validity rather than psychometric validity. This shift can be seen as a movement away from 'psychometrics' and towards 'clinimetrics' (Feinstein, 1987; Wright & Feinstein, 1992). Here the emphasis is not on constructing questionnaires with well defined variables and high internal validity as required for research, but rather to compose measures which are clinically meaningful and yield 'sensible' results which can be used by practitioners directly in their practice.

1.6 A central issue: how client change is measured

A key issue which underlies these debates between efficacy versus effectiveness research, and psychometrics versus clinimetrics, is the question of how data is actually collected. The dilemma faced by researchers and practitioners over which instruments to use when attempting to measure client change can be seen in a review of outcome measures by Froyd, Lambert, and Froyd (1996). The authors reviewed 334 studies which were published in 21 journals between 1983 and 1988. A staggering total of 851 completely different outcome measures were found to be in use. Even more telling, 840 of these measures were used in only a single study (Lambert & Hawkins, 2004). Rather than an isolated finding, Hill and Lambert (2004) found similar results in reviews by Ogles, Lambert, Weight, and Payne (1990 cited in Hill and Lambert, 2004) and Farnsworth, Hess and Lambert (2001 cited in Hill and Lambert, 2004). Though there have been calls for the use of a standard 'core battery' of measures (Strupp, Horowitz, & Lambert, 1997), Hill and Lambert (2004) concluded that the measurement of outcome in counselling and psychotherapy is in a state of chaos! In more measured terms, they highlight that:

A central issue in outcome research is how to measure the changes that occur in clients as a result of their participation in therapy. A great deal of effort has been expended on understanding the effects of psychotherapy, yet the lack of agreement in what constitutes adequate outcome measurement can create many problems when interpreting study results. (p.105)

1.7 The present study

It is in this setting that the present study was undertaken. The intent of the study was not to create yet another outcome measure with which to litter the field, but to critically enquire into an alternative approach to investigating the outcomes of counselling and psychotherapy from the

client's own perspective. Rather than adding to the existing 'chaos', the study was designed to shed new light on the issues of outcome measurement by enquiring into what is meaningful and valuable for clients. Here the focus is not on validity and reliability from a psychometric perspective, or indeed even 'sensibility' from a clinimetric perspective, but rather on constructing an approach which has value to clients themselves. This can be seen as an attempt to re-orientate Hill and Lambert's (2004) concern about the lack of professional agreement or consensus on the appropriateness of outcome measures to concern with what is adequate and appropriate for the participants within therapy research, and indeed the users of therapeutic services. Here, McLeod's (2001c) call for more qualitative approaches to outcome research has been influential, where the focus is more on 'hearing the client's voice' than defining standardised outcome criteria. Further, the idea that visual approaches may yield a different 'view' of therapy outcomes was influenced by Deacon's (2000) encouragement that qualitative researchers employ more creative and dynamic methods for collecting data that engage participants more fully.

Central to this process of investigating a qualitative, visual approach to evaluating the outcomes of counselling and psychotherapy was a desire to more fully engage the client's perspective or what Rogers (1951a) termed an individual's 'frame of reference'. Rather than predefining the dimensions of what an appropriate 'outcome' should be, the intent was to provide clients with a method to help reflect on and evaluate the significance of the changes in their life for themselves. Further, the interest was not just in exploring changes in a person's 'psyche', but in their wider social world or 'life-space' (Lewin, 1936). These and other influences are discussed more fully in the theory section which highlights the view of the client as being an active agent, drawing on and making use of the various resources and tools available. Here the different methods for evaluating outcomes can be seen as another 'resource' which clients may find more or less useful.

To this end, a review of existing methods for evaluating the outcomes of counselling and psychotherapy was undertaken with this 'client's eye view' in mind. In the following literature review, a cross section of traditional quantitative outcome measures will be presented, followed by a discussion of their potential limitations, particularly from the client's perspective. After this, a number of qualitative approaches to collecting self report data on the outcomes of therapy are reviewed. Though these qualitative approaches can be seen to have a number of advantages over traditional questionnaires, limitations exist in terms of the methods' reliance on linguistic and cognitive communication. Here visual methods can be seen to address the limitations of using words and numbers alone, and a number of approaches are presented which potentially offer a better 'fit' for investigating the dynamic, multidimensional, and 'lived' outcomes of counselling and psychotherapy.

The study itself is a mixed method design, utilising both quantitative and qualitative methods. It can be seen to draw on McLeod's (2001c) conceptualisation of research as 'bricolage', whereby the

method emerges in response to conducting the study. For example, the initial idea for the study emerged from dissatisfaction with previous research conducted by the researcher using only post-therapy interviews. The original concept behind the study was for participants to draw a 'picture' before they came to therapy to help them recall how things were when asked at the end of their counselling. This developed through reading about the concept of the life-space to become the Life Space Map. However, it became apparent that some form of comparison to using a standard outcome questionnaire would be beneficial so a quantitative aspect was introduced. As the study progressed, it was found that providing participants with a graphical representation of their quantitative data was a more 'like for like' comparison than just showing them the actual questionnaire or the total scores. During the write-up, it became evident that the visual approach lent itself best to a case study design so this was incorporated in the results alongside the quantitative data and thematic analysis. As the case study took shape, the emergent narratives coalesced around themes familiar to the researcher from other case study methods he had been involved with.

The resultant study was hence an ongoing piece of work 'under construction' and continually evolving. In this light, the following write-up is best seen not as a finished 'end product', but rather the documentation of an ongoing process. Significantly more data was collected than could be fully analysed in the time available. As such, the presented results are an example of what can be done with the collected data, but far from all that can be done. Further, the structure and form of the thesis mean that the presentation is limited to relatively brief excerpts of transcripts and small scale reproductions of the Life Space Maps. This does not do justice to the often poignant spoken words of participants, nor the full impact of large scale maps full of colour and different textures, some measuring up to half a square meter in size. Perhaps most significantly, the full implications from the study are still being digested by the researcher. Rather than being a culmination of knowledge and understanding as first envisioned, the study has been more of a process of revealing further questions, of opening new doorways of enquiry that will require other expeditions to explore fully.

2 LITERATURE REVIEW

Numerous reviews of counselling and psychotherapy outcome measures have been conducted, usually critiquing instruments in terms of their psychometric properties (e.g. reliability, validity, norms etc), their suitability for use with various diagnoses (e.g. depression, anxiety, OCD, PTSD etc), or clinical populations (e.g. inpatients, outpatients, adults, children, families etc). However, no reviews have been undertaken to critique outcome measures in terms of their suitability to measure changes in therapy from the client's own frame of reference. The current review will begin by looking at a cross section of traditional quantitative self report measures and discuss their usefulness for gathering meaningful data from the client's perspective. This section of the review will start with more psychometrically based measures and progress to a review of measures more usable in a clinical setting. Though this movement from 'psychometrics' to 'clinimetrics' can be seen as a progression towards more client orientated measurement, the underlying quantitative nature of these measures poses some fundamental limitations which are discussed in detail. As an alternative to this traditional quantitative approach, qualitative methods would appear to offer an approach to collecting data which is closer to the client's own frame of reference. The second part of this review will present various qualitative, self report data collection methods and discuss their potential limitations and merits for investigating the outcomes of counselling and psychotherapy, particularly from the client's perspective. These qualitative methods can be seen to have a number of benefits over traditional quantitative questionnaires, but can still be seen as potentially limiting with respect to their reliance on verbal communication. The final part of this review will look at visual methods of data collection which it is proposed have the potential to access the client's perspective more fully than either words or numbers alone.

2.1 Part 1: Standardised self report questionnaires

Self report questionnaires are currently the most widely used method for measuring the outcomes of counselling and psychotherapy (McLeod, 2003). For instance, in a review by Froyd, Lambert, and Froyd (1996) of outcome measures used in published studies between 1983 and 1988, the vast majority of measures were self report questionnaires. Specifically, they found that "the typical measurement practice is a paper-and-pencil instrument on which an individual rates his or her own behavior including feelings of being distressed (symptomatic states)" (Froyd et al., 1996. p. 14).

Self report questionnaires typically consist of a list of questions, statements or observations, often referred to as 'items'. Each response to an item is assigned a numerical value, either a simple binary value (e.g. 1=True, 0=False) or using some sort of intensity scale (e.g. 0=Never through to

5=Always). The values are then totalled according to a standardised schema to produce scores on one or more scales or dimensions (e.g. overall psychological distress, level of depression, functioning, etc). Typically, a questionnaire is given to the client before therapy commences, then again some time later (usually the end of therapy), and the change in scores calculated to give a representation of the success or not of therapy.

Though conceptually straightforward, there are many issues which influence the design and utility of such self report questionnaires. For example, from a theoretical perspective, the more questions there are that address the same factor, the more reliable and valid a questionnaire is likely to be. However, the longer a questionnaire, the more time it takes to complete, and the more demanding it is for participants. A questionnaire of 500+ items may be desirable in terms of producing an accurate psychometric assessment, but would be impractical as a repeated measure in a clinical setting. Alternatively, a short questionnaire designed to measure a specific factor (e.g. depression) may be convenient to administer, but may completely miss other important aspects of outcome. A questionnaire may be designed to be stable, returning reliable scores across a large sample of people in a clinical trial, but may be insensitive to change for the individual client in a practice based study. A questionnaire designed to be sensitive to change for one population (e.g. inpatients) may be completely insensitive to change when used with a different population (e.g. outpatients). Similarly, a questionnaire may be sensitive to the types of change that occur in one form of therapy (e.g. cognitive reframing from CBT) while being insensitive to change when used with a different form of therapy (e.g. insight from psychodynamic therapy).

These issues are reflected in many commonly used self report questionnaires. Following is an overview of a number of different styles of such questionnaires identifying their benefits and limitations, particularly with respect to their appropriateness for measuring the outcomes of counselling and psychotherapy from the perspective of the individual client who is completing it.

2.1.1 Personality assessment questionnaires (the MMPI-2)

Though designed primarily for use as diagnostic or screening tools, self report personality assessment questionnaires like the Minnesota Multiphasic Personality Inventory (MMPI) have been regularly used in outcome research (Farnsworth, Hess, & Lambert, 2001). In this setting, the personality 'test' is administered before and after therapy to determine if a client undergoes a shift from a 'clinical' personality towards a more 'normal' personality. In order to undertake as 'thorough' an assessment as possible, these questionnaires typically ask many hundreds of questions designed to measure a wide variety of symptoms.

The classic example of such a personality test, the MMPI, was originally developed in the late 1930s and first published in 1940 by Hathaway and McKinley (1940). In 1989 a completely revised

version, the MMPI-2, was published by Butcher, Dahlstrom, Graham and associates (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). The MMPI-2 contains a total of 567 questions which can be answered either True or False (e.g. “I work under a great deal of tension”, “I frequently find myself worrying about something”, “I am an important person”). The answers to these questions are statistically compared to ‘normal’ reaction patterns in order to assess a person using 10 basic clinical scales: Hypochondriasis, Depression, Hysteria, Psychopathic Deviate, Masculinity-Femininity, Paranoia, Psychasthenia, Schizophrenia, Hypomania, and Social Introversion (Butcher et al., 1989). A number of additional scales and subscales have been developed to aid interpretation of these primary scales such as the Restructured Clinical scales, the Harris-Lingoes subscales, and Social Introversion subscales.

The richness of interpretation that is possible with the MMPI-2 has made it popular for psychological and personality assessment, and has provided a large clinical data set which can be used to compare results (Piotrowski & Keller, 1989). Further, the MMPI-2 was specifically designed to enable ‘false’ or inconsistent responses to be identified, hence increasing its validity with unwilling respondents (Friedman, Lewak, Nichols, & Webb, 2001). This gives the MMPI a high level of credibility with regards to assessment of individuals, for example being accepted in a court of law as evidence. However, this ‘authority’ is not without controversy, especially as the popularity of the MMPI has led to its widespread use, at times without adequate clinical training. This is of particular concern when the instrument is used in isolation and without due consideration of its limitations.

With regard to use as an outcome measure for counselling and psychotherapy, personality tests such as the MMPI have a number of drawbacks. As these questionnaires are primarily designed to categorise a person into specific psychological diagnostic categories, they are not very suitable for measuring more subtle changes in an individual’s mental state over the relatively short time interval of therapy (Beutler & Crago, 1983). Perhaps the biggest drawback, however, is the size of the questionnaire. The MMPI-2 can take between 60 to 90 minutes to complete, which is longer than most therapy sessions. This is particularly prohibitive from the perspective of asking a person to complete the questionnaire multiple times, especially if this is in conjunction with another outcome measure. Further, requiring a 576 item ‘test’ to be completed prior to attending therapy may be too daunting for some clients, especially if they are already in a vulnerable or sensitive state of mind. For these reasons, multi trait personality questionnaires of this length and complexity are not usually recommended as outcome measures (Hill & Lambert, 2004).

The MMPI epitomises the emphasis of early self report measures on rigour for group design. The huge number of items are required in order to ‘test’ the participant from different angles, and even to ‘catch out’ a person making erroneous responses. Underlying this approach is a premise that a respondent is unreliable and needs to be checked and categorised using an expert system designed

to minimise error. As such, the MMPI provides a good example of a measure that has strong psychometric properties but almost no positive clinimetric properties.

2.1.2 Symptom based assessment measures (the SCL-90-R)

Unlike personality tests discussed above which try to categorise a respondent's personality, symptom based measures such as the Symptom Checklist 90 (SCL-90-R) attempt to measure levels of distress along predefined clinical scales. Ideally, such measures provide a way of measuring a broad range of symptomatic distress, ranging from mild loss of well-being through to severe states of distress more commonly associated with psychiatric disorders (Derogatis & Fitzpatrick, 2004). Rather than asking discrete binary (True/False) questions such as in the MMPI, symptom based measures such as the Symptom Checklist 90 (SCL-90-R) tend to use a variable response scale allowing respondents to report different intensities of symptoms.

An example of this approach, the SCL-90, was developed in the 1970s from the Hopkins Symptom Checklist (HSCL), itself a development of earlier scales from the 1940s (the Cornell Medical Index) and 1950s (the Discomfort Scale) (Derogatis & Savitz, 1999). The latest revised version, the SCL-90-R, was released in 1992 and contains a list of 90 problems and complaints which people may experience. For each item, the respondent is asked to rate on a 5 point Likert scale from 'Not at All' to 'Extremely' how much discomfort each problem has caused them over the last week. From these ratings, 9 primary symptom dimensions are calculated (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism). Additionally, three global indices of distress (Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total) are measured (Derogatis, 1992).

The relative brevity of the SCL-90 means that it can typically be completed in around 15 minutes (Derogatis & Savitz, 1999), making this questionnaire more viable as an outcome measure for counselling and psychotherapy than personality assessment questionnaires such as the MMPI discussed above (Hill & Lambert, 2004). The SCL-90 also provides a set of normative data for psychiatric inpatients and outpatients, and community non patients and adolescents. This normative data can be used to compare results in order to establish the clinical significance of any change in score from before until after therapy (Jacobson & Truax, 1991). Further, the SCL-90 has been demonstrated to be sensitive to change over the duration of therapy (Derogatis & Fitzpatrick, 2004), again making this instrument more appropriate as an outcome measure than personality tests discussed above.

From the perspective of the individual client completing the SCL-90, the main critique of the measure is probably that it attempts to do too much. In order to measure the nine theoretical symptom dimensions, a large number of related questions are used in an attempt to establish

adequate content validity. However, numerous studies have demonstrated that these theoretical symptom dimensions do not really stand up to scrutiny when factor analysis is performed (Cyr, McKenna-Foley, & Peacock, 1985). Such studies tend to suggest that like most symptom based questionnaires, a single dimension of distress versus non-distress is most prevalent. As such, researchers typically use the Global Severity Index as a single summary measure, discounting the separate symptom scales as unreliable. This would seem to call into question the point of using the SCL-90 when shorter, less time consuming measures are available.

2.1.3 Symptom specific assessment tools (the BDI-II)

Whereas general symptom based measures like the SCL-90 attempt to measure a broad range of problems, symptom specific assessment tools such as the Beck Depression Inventory (BDI) attempt to measure just one dimension of a person's distress (e.g. depression, self esteem, anxiety etc). The BDI, for example, is designed to only assess the intensity of depression, and a separate measure, the Beck Anxiety Inventory (BAI), would need to be used for assessing anxiety. This allows such measures to be considerably shorter and more focused than those attempting to cover a broader range of problems.

As a typical example of this type of measure, the BDI was developed in the 1960s and revised in 1971, with the latest version, the BDI-II, released in 1996 to cater to changes in the DSM-IV. The measure consists of 21 items, each item being a list of four statements arranged in increasing severity about a particular symptom of depression (e.g. I don't feel disappointed in myself; I am disappointed in myself; I am disgusted with myself; I hate myself). Each statement is scored from 0 to 3 in terms of increasing severity, with an overall score of 1-10 being normal, 11-16 being mild mood disturbance, 17-20 being borderline clinical depression, 21-30 being moderate depression, 31-40 being severe depression and over 40 being extreme depression (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Though primarily designed as a pre treatment assessment tool for clinicians, the BDI has become widely used as a counselling and psychotherapy outcome measure (Farnsworth et al., 2001). One reason for this popularity is the relative brevity of the measure. The BDI takes only 5 to 10 minutes to complete which makes it especially useful when multiple measures are used at the same time. It is particularly relevant to studies that specifically investigate depression, though it is also used as a general outcome measure.

Despite this relative popularity, Hill and Lambert (2004) identify a fundamental limitation of symptom specific measures such as the BDI. They point out that although the questionnaires often give the impression of precisely measuring a single symptom (e.g. depression), the measures are often highly correlated with other measures presumed to assess a completely different symptom (e.g. anxiety). This brings into question the basic construct validity of the measure (i.e. the ability of the questionnaire to measure legitimately the concept that it claims to measure). They warn that

researchers need to be aware that these measures provide less precise information than their names imply.

From an individual client's perspective, though these measures are relatively simple and easy to complete, a concern exists that the outcome of therapy indicated by the questionnaire may be distorted. On the one hand, as the questions are designed specifically to assess a single symptom, significant changes in other symptoms may go undetected leading to an under-representative indicator of change. On the other hand, while the questionnaire may indicate significant changes to the symptom they were designed to measure, significant *lack* of change in other symptoms may go unnoticed leading to an over-representation of change. Similarly, such measures tend to focus only on negative symptoms such as sadness, anxiety, irritability etc, potentially missing more positive coping mechanisms giving a skewed representation of a client's situation (NHS Health Scotland, 2005). In combination with Hill and Lambert's (2004) warning, it would seem ill advised to use this type of measure as the sole outcome indicator of a study.

2.1.4 Practice based outcome measures (the OQ-45.2 & CORE-OM)

Practice based measures such as the OQ-45 (developed in the US) and the CORE-OM (developed in the UK) have been designed in collaboration with counselling and psychotherapy practitioners to specifically evaluate individual client improvement in clinical settings. Unlike the previous questionnaires discussed which have largely originated out of the need for psychological screening measures in medical or scientific settings, these two measures were designed from the ground up with the practical requirements of routinely monitoring outcomes of counselling and psychotherapy in mind. As such, they were designed to be relatively easy to administer and score, with low to no costs per administration, while being sensitive to changes in psychological distress over relatively short periods of time and tapping into a wide variety of characteristics typically associated with mental health functioning (Lambert, Gregersen, & Burlingame, 2004). Further, they aim to provide clinical improvement standards based on actual *practice* rather than rely on those set from research conducted in artificial settings (Wells, Burlingame, Lambert, Hoag, & Hope, 1996).

The Outcome Questionnaire (OQ-45) was initially developed in the 1990s by Michael Lambert and colleagues (Lambert et al., 1996) after an extensive review of existing outcome measurement practices such as that composed by Froyd, Lambert, and Froyd (1996). The aim was to construct a standardised indicator of change in therapy which practitioners could use to demonstrate the efficacy of their practice in the "age of accountability" (Wells et al., 1996). As such, the OQ-45 has a relatively low time overhead compared to other generalised outcome measures requiring approximately 5 minutes to complete (compared to 15 minutes for the SCL-90) and under 10 minutes to score. Rather than attempt to generate scores for a specific clinical diagnosis (e.g. depression, anxiety etc), the OQ-45 was designed to measure the broader level of symptoms of

psychological distress, along with interpersonal functioning, and social functioning (in work, school, or primary role pursuits). The 45 items on the questionnaire are responded to using a 5 point Likert scale (Never, Rarely, Sometimes, Frequently and Almost Always), and are grouped into three sub scales. The Symptom Distress subscale (25 items) contains items predominantly for symptoms of depression and anxiety, and two for substance abuse. The Interpersonal Relations subscale (11 items) attempts to measure friction, conflict, isolation, inadequacy, and withdrawal in intimate relationships, along with one item for substance abuse. The Social Role Performance subscale (9 items) focuses on dissatisfaction, conflict, distress, and inadequacy in tasks related to employment, family roles, and leisure life. Five items are also used to assess Risk (Lambert, Gregersen et al., 2004).

Similarly, the CORE-OM (Clinical Outcomes in Routine Evaluation – Outcome Measure) was developed in the 1990s by the CORE System Group (1998) to be a pragmatic, user friendly measure that could easily be utilised by practitioners. Specifically, the designers aimed to produce a measure which was pan-theoretical, relatively short, easy to score and interpret, clinically sensitive to change, and possessed adequate scientific validity and reliability (Barkham et al., 1998). The process of constructing the questionnaire included extensive consultation and collaboration with service providers and practitioners (Evans et al., 2000). The resultant 34 item questionnaire is grouped into four theoretical domains: 12 items for Problems and Symptoms, 12 items for Life Functioning, 4 items for Subjective Wellbeing, and 6 items for Risk. These domains are further divided into clusters: Depression, Anxiety, and Physical for Problems and Symptoms; General, Social and Close relationships for Life Functioning; and Risk to Self and Risk to Other for the Risk domain (Barkham, Mellor-Clark, Connell, & Cahill, 2006). Of the 28 non-risk items, 14 are designed to be high intensity (e.g. “I have felt panic or terror”) and 14 are low intensity (e.g. “I have felt tense, anxious or nervous”) to increase sensitivity. 25% (8) of the items are positively framed (e.g. “I have felt optimistic about my future”) and the rest are negatively framed (e.g. “I have felt despairing or hopeless”). Each item is responded to using a 5 point Likert scale (Not at all, Only occasionally, Sometimes, Often, and Most or all the time) and the whole questionnaire can be completed in around 5 minutes (CORE System Group, 1998).

Both measures extensively utilise the concept of reliable and clinically significant change proposed by Jacobson and colleagues (Jacobson & Truax, 1991). A questionnaire is given to the client at the beginning and end of therapy. If a client’s total score starts in the ‘clinical’ range, then moves to the ‘non-clinical’ range at the end of therapy, then the person is said to have undergone clinically significant improvement. Additionally, the change in score must be of sufficient magnitude to be scientifically reliable, and not due to measurement error. Both the OQ-45 and CORE-OM have sufficient ‘normative data’ to allow these calculations to be made, giving practitioners a simple yet scientifically accepted means of evidencing their practice. Further, Lambert and colleagues have developed a method for using the OQ-45 as an ongoing treatment monitoring tool (Finch, Lambert,

& Schaalje, 2001). Rather than just completing a questionnaire at the beginning and end of therapy, clients are asked to complete the OQ-45 before every session. The client's weekly scores can then be plotted against an 'expected recovery curve', allowing actual progress in therapy to be compared to theoretically expected progress. Different 'recovery curves' are hypothesised depending on the initial level of distress of the client, allowing, for example, greater tolerance levels for 'mild' entry points as compared to 'severe' entry points. This allows a 'signal alarm' system to be implemented, whereby if a client's score goes significantly 'off track', the case can be signalled as a potential treatment failure (Lambert, Hansen et al., 2001). Significantly, Lambert's research programme has identified that this method can be used to enhance therapy outcomes by alerting practitioners to cases that are 'off track', allowing therapists to address potential issues in the therapy (Lambert, Whipple, Smart, Vermeersch, & Nielsen, 2001).

From the individual client's perspective, these measures have a number of benefits compared to the outcome questionnaires discussed above. Firstly, the questionnaires have been specifically designed to be 'user friendly' and as such are relatively easy to read and comprehend, and are fairly short. Secondly, the items of the questionnaires have been specifically selected to be applicable to counselling and psychotherapy, rather than personality assessment or psychological screening. As such, they are intended to reflect every day concerns and problems that people experience, rather than more esoteric clinical diagnostic categories. Thirdly, the measures are designed to be sensitive to individual change in clinical settings, giving clients the opportunity to 'see' change in terms of a shift from 'clinical' to 'non-clinical' scores. Lastly, and perhaps most significantly, the 'signal-alarm' system developed for these practice based measures offers the potential for individuals to give their therapist direct feedback on how they are doing in therapy, and hence an opportunity to non-confrontationally inform the therapist when things are not going well.

Although the OQ-45 and CORE-OM offer a significant improvement from previous questionnaires for looking at the outcomes of counselling and psychotherapy from the individual's perspective, they also inherit some of the limitations discussed above. Both questionnaires still attempt to construct subscale domains and hence impose questionable theoretical interpretations on the person's responses. Similar to the critique of the SCL-90, factor analysis of such subscales has repeatedly discounted the presence of meaningful groupings of responses, instead indicating that a single dimension of distress is being measured (e.g. Mueller, Lambert, & Burlingame, 1998; Lyne, Barrett, Evans, & Barkham, 2006). Related to this, both questionnaires were developed by researchers and practitioners rather than in collaboration with clients. As such, both questionnaires encompass an underlying theoretical construction which may have little to do with what clients consider to be significant indicators of change. For example, CORE-OM is constructed to be compatible with the phase model of change which suggests a sequential impact on subjective well-being early in therapy, progressing to symptoms, and then to aspects of life functioning (CORE System Group, 1998). However, research evidence again discounts the ability of such measures to

tap accurately into discrete dimensions of change (Lyne et al., 2006), making the attempt to construct the questionnaire to fit the model superfluous. This would suggest that removing the design constraints of multiple subscales or theoretically orientated constructs could result in a briefer, more succinct and potentially more relevant questionnaire.

2.1.5 The trend towards abbreviated outcome measures (the BSI/BSI-18, OQ-30/10 & CORE-18/10)

A distinct trend has emerged over the last decade or so towards the abbreviation of existing, well validated measures into shorter, more succinct measures. This trend has paralleled the growing emphasis within the counselling and psychotherapy field on accountability and the need to evidence the efficacy of practice. Rather than prioritise scientific validity and rigour, this trend reflects the needs of clinical settings to adopt practical, efficient solutions to outcome monitoring that are not overly burdensome on clients or practitioners. Here, shorter measures that ‘do the job’ are preferable to longer measures which may have greater scientific validity.

An example of this trend can be seen in the development of the BSI-18, an abbreviated version of the SCL-90 discussed above. Initially this measure was abbreviated into the Brief Symptom Inventory (BSI), a 53 item questionnaire with the same theoretical structure as the longer version. Scores from the BSI have shown strong correlation with the SCL-90, suggesting that the shorter measure is equivalent in use to the longer (Derogatis & Savitz, 1999). More recently, the BSI-18 was developed in 2000 to provide a brief screening measure for psychological distress in medical and community populations, and secondarily as an outcome measure. Unlike its predecessors however, the shorter 18 item questionnaire does not have the same theoretical structure. Rather than the nine symptom dimensions of the SCL-90/BSI, the BSI-18 has been reduced to three (Somatization, Depression, and Anxiety) considered the most relevant for clinical practice (Derogatis & Fitzpatrick, 2004). This is an example of the potential benefits of reducing the theoretical design constraints, whereby two thirds of the original theoretical structure is dropped allowing an 80% reduction in the length of the questionnaire.

Similarly, the OQ-45 has two abbreviated versions, the OQ-30 (also known as the Life Status Questionnaire or LSQ) and the OQ-10 (also known as the Outcome Questionnaire Short Form). The OQ-30 was developed using research which identified the items on the OQ-45 which were most sensitive to client change over the duration of therapy (Vermeersch, Lambert, & Burlingame, 2000; Vermeersch et al., 2004). The 30 most sensitive items which also demonstrated relative stability across similar client groups were selected to construct a briefer, easier to administer measure (Brown, Burlingame, Lambert, Jones, & Vaccaro, 2001). The OQ-10 was developed by Lambert and colleagues as a brief, unobtrusive instrument for screening primary care patients for psychological distress. Items were selected from the OQ-45 on the basis of those which best

discriminated between a 'community' non-clinical sample and a sample of patients diagnosed with DSM Axis-I disorders (e.g. anxiety and depression). Though the resultant 10 item questionnaire is intended primarily as a screening tool, its psychometric properties suggest that it has the potential to be used as a very brief outcome measure, correlating highly (0.75, $p < .01$) with the global scale of the SCL-90 (Maruish, 2002). Interestingly, factor analysis of the items suggests that this questionnaire measures two dimensions, "psychological wellbeing" from five positively worded items and "psychological distress" from five negatively worded items (Seelert, Hill, Rigdon, & Schwenzfeier, 1999).

A number of short forms have also been developed from the CORE-OM. Two 'short form' 18 item questionnaires were produced early in the development of the CORE system to provide researchers with a pair of repeated measures which could be given to clients at alternate sessions. The rationale of using two similar measures was to reduce the "memory effect" of completing the same questionnaire each week (Cahill et al., 2006). Both measures (known as the SFA and SFB) contained the same four Wellbeing items as the original 34 item questionnaire. The remaining 14 items were different in each parallel version, with 6 Problem items, 6 Functioning items, and 2 Risk items, again sourced from the original 34 item questionnaire (Barkham et al., 2001). Recently, the CORE 10 has been developed in response to the demand for a brief, efficient measure which places minimum demands on clients and practitioners (Connell & Barkham, 2007). The 10 items of the questionnaire allow a simple summation of the item scores to obtain the 'clinical score', making this measure especially easy to administer. Further, the items were selected to still cover a broad range of problems and issues including anxiety, depression, trauma, general functioning, close relationships, social relationships and risk. Additionally, the designers included both high intensity items (6) and low intensity items (4) to increase sensitivity and avoid ceiling effects. Like the OQ-10 discussed above, the CORE-10 would appear to have good psychometric properties correlating highly with much longer standardised outcome measures (e.g. 0.81 for the SCL-90) (Connell & Barkham, 2007).

The OQ-10 and CORE-10 demonstrate that it is possible to produce a psychometrically sound yet brief outcome measure which is designed to be easy to utilise in practice settings. The experience gained and data gathered from research using the full version of the measures have allowed designers to focus on items that appear most relevant to obtaining meaningful responses from clients. This would seem to offer the benefit to clients of not having to answer superfluous questions in order to gain the same result, as well as a significant reduction in the time required to complete the questionnaires. However, questions also arise from the development process of these questionnaires. These short versions directly inherit items and rating scales from their longer forms in order to be able to utilise existing psychometric data. Little research has been undertaken to confirm the validity of this process, with developers largely relying on extracted data to establish

validity and reliability data rather than using stand alone versions of the questionnaires in separate studies.

2.1.6 Ultra brief ongoing monitoring questionnaires (the CORE-5 & ORS)

The trend towards ever briefer self report measures has potentially reached its pinnacle with the CORE-5 and ORS (Outcome Rating Scale). Designed for ongoing monitoring of weekly sessions rather than as sole outcome measures, these questionnaires are intended to give practitioners a tool to quickly obtain a rating of the client's current level of distress. As such, they are not intended for research as they do not possess sufficient psychometric properties to enable meaningful statistical analysis to be undertaken. They do, however, offer a convenient alternative to longer measures for tracking a client's progress or lack of progress from week to week. Indeed, both these brief measures have specifically been designed to be used in conjunction with other measures as part of an ongoing, session by session monitoring system similar to that proposed by Lambert and colleagues (Lambert, Hansen et al., 2001) for the OQ-45 discussed above.

The CORE-5 comprises just five items for anxiety, depression, functioning and well being. These items are taken directly from the original 34 item CORE-OM and are rated on the same 5 point Likert scale. Specifically, the items consist of "1. I have felt terribly alone and isolated", "2. I have felt OK about myself", "3. I have felt panic or terror", "4. I have been happy with the things I have done", and "5. I have felt despairing or hopeless". There are two positively worded, low intensity items (2 & 4) and three negatively worded, high intensity items (1, 3 & 5). Only two of the items (3 & 5) are consistent with the CORE-10. Rather than attempt to provide a scientifically accurate rating of distress, the measure is intended to act as a 'thermometer' for practitioners on a week by week basis (Barkham et al., 2006). The CORE-5, along with the CORE-10, forms an integral part of a new online web based real time data collection and monitoring system known as CORE Net (CORE Information Management Systems, 2008). This system provides practitioners with an effective yet efficient ongoing outcomes monitoring system which can help maximise potential client gains (Gray & Mellor-Clark, 2007).

In comparison, the ORS (Outcome Rating Scale) uses a 4 item 'analogue' scale design. Clients are asked to rate how well they have been doing in four aspects of their life: Individually (personal well-being), Interpersonally (family, close relationships), Socially (work, school, friendships) and Overall (general sense of well-being). These items were adapted directly from the subscales of the OQ-45.2, namely Symptom Distress, Interpersonal Relations and Social Role Performance (Miller, Duncan, Brown, Sparks, & Claud, 2003). Rather than a 5 point Likert scale like most of the previous questionnaires discussed, clients are asked to mark how they are feeling using a 10cm long line, with marks to the left representing low levels, and marks to the right indicating high levels for each item. Items are scored to the nearest centimetre and added, giving a total maximum

score for the measure of 40, with a clinical cut off of 25 meaning scores above 25 are ‘non clinical’ (Duncan, Miller, & Sparks, 2004). Like the CORE-5, the ORS was specifically developed to be part of an ongoing client monitoring and feedback system. The Partners for Change Outcome Management Systems (PCOMS) uses the ORS in conjunction with the Session Rating Scale (SRS), a therapeutic alliance measure, to give practitioners direct feedback on sessions (Miller, Duncan, Sorrell, & Brown, 2005). An online version of this system is also available which even offers the potential for clients to follow their own progress (Danya International, 2007).

From the client’s perspective, the brevity of the CORE-5 and ORS allow the measures to be completed and scored in less than a minute, and allows the feedback obtained to be used directly in the actual session rather than needing to wait for the data to be processed. Similar to the ‘signal alarm’ system of the OQ-45 (Lambert, Whipple et al., 2001), this feedback can offer clients a further ‘voice’ about their experience of the therapy. Further, the authors of the ORS claim that the measure is less distant from clients’ day-to-day or lived experience so they can immediately translate the questionnaire’s generalised items into the specifics of their circumstances (Duncan et al., 2004). In this way, the ORS is intended to act as a framework upon which the client can construct their own individual meaning. The significant aspect here is that it is the client rather than the therapist or researcher that imbues the measure with meaning.

One of the key motives for developing abbreviated outcome measures is to reduce the impact and burden on both clients and practitioners with regard to the time taken to complete the questionnaires. However, there appears to be no published research into the actual experience of clients with respect to their view of completing such measures, especially in regard to the therapeutic process. Indeed there is potential that clients may feel restricted or even frustrated by the reduced number of items available on such abbreviated measures, such that they can not accurately reflect their current state of being with the limited options available. Further, there is potentially a loss of clinical value in terms of a client being able to ‘check in’ against a longer list of problems and difficulties to help them gain a focus on what is ‘around’ for them. Research into the actual acceptability and utility of these brief outcome measures against longer, more in-depth questionnaires is significantly absent from the literature.

2.1.7 Personalised questionnaires (the PQRST & Simplified PQ)

Unlike the previous questionnaires discussed which use predefined items, personalised questionnaires are constructed in dialogue with the client such that the items they contain are idiosyncratic to the individual. These questionnaires allow the client to construct their own set of statements which are directly relevant to them and the problems they have come to therapy for.

This technique was first introduced into therapy research by Monte Shapiro (1961). Shapiro's questionnaire was constructed over a number of stages, starting with the researcher using a standardised interview to elicit a list of statements about a person's current condition. These statements were then reformulated by the researcher to provide two further statements – one for an 'improvement' statement, and another for a 'recovery' statement. This resulted in three statements for each 'item' covering the spectrum from 'illness' through 'improvement' to 'recovery' (e.g. "I have not got any energy", "I have a little energy", and "On the whole I have some energy"). Each statement was then typed up on a separate index card and the person asked to rate the unpleasantness of each using a modified Singer-Young Affect Rating Scale from "Very great unpleasantness" to "Very great pleasure". This allowed the 'standardisation' of each item, with any statement not fitting the required level of unpleasantness being reformulated until it did. Next, the three questions for each item were paired with each other and typed onto a further set of cards with one statement above the other, resulting in three 'paired' cards per item, each with a different intensity of condition on the top of the card than the bottom. To administer the questionnaire, a person was asked to sort a shuffled pack of these cards into two groups, one where the 'top' statement best matched their current state, and another where the 'bottom' statement best fitted (an ipsative, or 'forced choice' method). A complex scoring system was then used such that a matrix was formed for each item representing the selection of each of the three intensity statements against each other. This procedure allowed a check for the internal consistency of a person's responses, with the consistent responses being scored from 1 to 4 depending on the pattern of selection. Further details and discussion of this technique, along with a number of variations of the method are discussed in detail by Philips (1986).

This elaborate procedure resulted in a questionnaire completely tailored to the individual, both in item content and in scale points, but which still produced a standardised 'score' which could be compared both over time and between individuals/groups. However, the complexity of the procedures for both construction and scoring have led subsequent researchers to develop briefer, more streamlined procedures which are more usable in clinical practice settings. An example of this is the Personal Questionnaire Rapid Scaling Technique (P.Q.R.S.T.) developed by Mulhall (1976). This version entailed a reusable booklet rather than typed index cards. Unlike Shapiro's method which asked the participant to select from pairs of statements of varying intensity for each problem, this method used pairs of adjectives for each problem statement. e.g. "The embarrassment I feel in social situations is..." "very considerable" or "moderate". The booklet contained 12 pages, with differing pairs of adjectives from the range "absolutely none", "almost none", "very little", "little", "moderate", "considerable", "very considerable", "maximum possible" provided on successive pages for each statement. This procedure required the participant to choose which adjective of the pair was closest to their current state, allowing a similar internal consistency check as Shapiro's questionnaire, but significantly reducing the administration and scoring time. Mulhall (1976) states that the booklet required 15-20 minutes for the participant to complete the

questionnaire, and less than a minute to score using a specially devised scoring template. Chalkley and Mulhull (1991) further simplified this process by reducing the number of intensity adjectives from 8 to just 3 (“very little”, “moderate”, and “very considerable”). This allowed a reduction in the booklet size from 12 to 3 pages, with a consequent reduction in administration time to around 5 minutes. Though this scoring process lost the individualised intensity ratings of Shapiro’s original PQ, it benefited from increased practicality and usability in clinical settings. Further, it guaranteed a linear scaling of intensity which may not be clear when using varying statements of intensity as in the original PQ (Phillips, 1986).

A further simplification of the personal questionnaire approach has more recently been developed by Elliott and colleagues. The Simplified Personal Questionnaire (Elliott, Mack, & Shapiro, 1999) was developed to contain many of the concepts incorporated in previous versions on the personal questionnaire, but to also be easily administered as an ongoing monitoring measure. As such, the measure was designed to be very brief to complete and score, and to be easily interpreted. This required a compromise in the rating method used in the previous forms of the questionnaire where the selection between two statements or intensity adjectives was discarded in favour of a simpler Likert scale. The scale points were adapted from the Mulhall questionnaire and used as interval points on a 7 point scale where 1=“Not At All”, 2=“Very Little”, 3=“Little”, 4=“Moderately”, 5=“Considerably”, 6=“Very Considerably”, and 7=“Maximum Possible”. This simplification allows the Simplified PQ to be completed and scored in less than a minute, making it ideal as an ongoing monitoring tool. Further, Breighner and Elliott (2005) have adapted the signal alarm system developed by Lambert and colleagues (Lambert, Whipple et al., 2001) to be compatible with the Simplified PQ scoring. This has been integrated into a simple online tracking and monitoring system allowing direct feedback to therapists as well as providing a case management tool (Rodgers, 2008).

The personal questionnaire method provides an interesting example of combining an initial qualitative exploration sensitive to the idiosyncratic problems of the individual, with a standardised quantitative outcome measure that can be used to compare results across time and across settings. From the client’s perspective, the initial collaborative process of defining 10 or so problem statements may well act to enhance the therapy process by allowing a focus to be brought to what the person is looking to work on in therapy (McLeod, 2003). Further, the weekly use of the questionnaire may allow participants to ‘check in’ with themselves on how they have been doing over the last week in specific problem areas, and to monitor changes on a week by week basis. Tentative findings from an ongoing practice based study utilising the simplified personal questionnaire (Elliott, 2007b) suggest that clients use their PQ much as a ‘barometer’, getting an indicator of change and the general direction their therapy is going in.

However, it has been noted that the structure of the questionnaire does impose potential limitations from the client's perspective. Firstly, the statements derived during the initial construction phase are required to be 'problem' statements in order to fit the questionnaire's scale of "how much it has bothered you over the past seven days". This explicitly frames the statements as problems rather than goals, which may not 'fit' for some clients. Further, the problem statements are required to remain relatively fixed over the duration of therapy for the signal alarm system to operate correctly. If a client changes their focus during the course of therapy, the PQ items may significantly lose their relevance, meaning the weekly scores become an inaccurate representation of the client's actual level of distress (McLeod, 2003). For these reasons, it would seem advisable to regularly review the relevance of the PQ items with a client, and to combine the weekly use of the questionnaire with a broader measure of distress such as the CORE-OM or OQ-45 at intervals throughout the therapy.

2.2 Limitations of standardised self report questionnaires

Standardised self report questionnaires offer researchers a cost-effective method of assessing change in therapy which can be easily compared both within and across individuals and contexts. However, such questionnaires may also be fundamentally limited in their ability to accurately represent the changes that individuals experience from counselling (Meier, 1994; McLeod, 2000b). Following are a number of critiques of self report questionnaires, ranging from the philosophical, to the more practical problems that clients face when completing the seemingly simple task of answering a series of questions using a set of pre defined response points.

2.2.1 Psychometrics as inherently unscientific

From a philosophical perspective, Michell (1997; 2000) argues that the current practice of quantification in psychology is fundamentally flawed. He believes that the assumptions upon which psychometrics are based are inherently unscientific, and that they represent a 'pathological' lack of acknowledgement of the implicit methodological limitations involved (Michell, 2000). Here, Michell (1997) is referring to the adoption by psychology of Steven's 1946 theory that measurement is "*the assignment of numerals to objects or events according to a rule*" (p. 360). In contrast, Michell (1997) states that measurement is properly defined as "*the estimation or discovery of the ratio of some magnitude of a quantitative attribute to a unit of the same attribute*" (p. 358). Put simply, this is stating that measurement is the attempt to discover or estimate the *existing* 'quantitative structure' of what is being measured, not just putting numbers to things. For example, the concept of 'length' lends itself to measurement because it has an existing 'quantitative structure' - there is an existing logical structure and relationship between different attributes of 'length' which can be discovered.

Michell's (1997) assertion is that within psychology, the underlying hypothesis of the quantitative structure of psychological constructs has remained untested. As such, all attempts to measure psychological attributes are fundamentally flawed. For example, no attempt has been made to demonstrate that 'depression' is a quantitative attribute, and yet measures of depression freely assume that it is. The BDI discussed above assumes that responses to statements are interval data which can be added together to form a total score, and can be statistically compared across time or groups. What Michell is challenging is the assumption that, for example, "I am so sad or unhappy that I can't stand it" can uncomplicatedly be added to "I feel I may be punished" as if they were on the same linear dimension. If this assumption can not be justified, then all the resulting statistical calculations are meaningless, along with all the results of research studies that utilise such measures. Michell's claim of 'pathology' within psychology is based on the view that even though these assumptions are well known to be questionable, the field treats them as hard facts, hence turning a blind eye to this fundamental flaw and carrying on as if nothing was wrong.

2.2.2 The constraints of naturalism

Slife (2004) takes this philosophical critique further and questions the underlying naturalistic foundations of objectivism, materialism, hedonism, atomism and universalism upon which standardised self report measures are constructed. With regard to objectivism, Slife contends that all approaches to research have underlying values, and the approach we adopt will always have an impact on the outcome we obtain. The idea that the logic of naturalistic scientific method is 'objective' and does not favour one type of therapy over another is seen as flawed. Slife asserts that "the scientific method may provide empirical justification for certain therapeutic techniques, but it provides no empirical justification for itself and the philosophies that ground it." and "Like all philosophies, they have philosophical axes to grind and pre-investigatory values to assert" (Slife, 2004 p. 50). An example that is given of this is the emphasis placed by traditional scientific method on what is observable and replicable. It is assumed that these aspects of reality are what is important, and are worthy of our focus, but this is a philosophical and moral assumption, not a hard fact.

By focusing on what is observable and measurable, researchers have to attempt to 'operationalise' (i.e. find a way to define something in terms of a measurable quantity) what they are investigating. This materialism inherently misses that which can not be measured, such as the spiritual, cultural, transpersonal or existential aspects of therapy, and even some relational elements of therapy (as only the things having the relationship can be observed, not the relationship itself). This can lead to a study of the manifestation of a phenomenon, not the phenomenon itself, and even worse, to the assumption of a causal relationship between the two. As quoted from Valenstein (1998, p. 126) "no one would suggest that the carrying of an umbrella causes rainfall, although the carrying of an

umbrella is highly associated with rain” (as cited in Slife, 2004 p. 56). Further, it is up to the researcher to choose which manifestation represents which phenomena prior to undertaking a study, such that this choice becomes an implicit part of the method, so is usually never questioned. “The upshot is that we cannot know for sure with traditional scientific methods what is actually being studied in our research investigations because we cannot know with certainty what a particular operationalization means” (Slife, 2004 p. 55).

A further critique is that of ‘hedonism’ which contends that most traditional therapy outcome measures tend to focus on the betterment of self. This places severe constraints on the research of the meaning and purpose of suffering, self sacrifice and other aspects that do not fit with this assumed aim of therapy. There is no place for the study of “the redemptive power of suffering, acceptance of one’s lot in life, adherence to tradition, self-restraint and moderation” (Frank, 1978, p. 6-7, as cited in Slife, 2004 p. 64) as these do not fit with our modern ‘Western’ value system. The potential of finding meaning in suffering without necessarily eliminating it, of helping people to experience greater purpose in life without necessarily ‘taking away the pain’ or ‘making it better’ is typically overlooked.

Similarly, by adopting an atomistic approach and focusing on the individual, traditional psychotherapy outcome research methods miss the wider social context, and risk supporting and re-emphasising cultural biases inherent in ‘Western’ psychotherapy theories. Further, by assuming that problems are ‘contained’ in the client, and that these can uncomplicatedly be brought to the research setting to be measured, contextual elements of the process and outcome of therapy are inherently missed. Clients’ problems may well not be ‘self contained’, but instead be dependent on situation, setting, and specific interpersonal dynamics and hence qualitatively different within the research setting versus outside of it.

Finally, the universalism of traditional research tends to focus on commonalities, on what is generalisable and permanent. This misses the qualitative differences between clients, and the unique aspects to their situation, which typically are ‘controlled’ for in an attempt to discount their influence on a study. This approach also discounts one off events, even though these may be incredibly significant to a person (e.g. spiritual awakening). By discounting these aspects, traditional research inherently limits its attention to an artificially narrow perspective, and effectively loses a lot of data that may be significant.

2.2.3 An administratively created reality

Rather than challenging the predominant use of self report measures in counselling and psychotherapy research in terms of fundamental scientific principles, McLeod (2001a) highlights the historical ‘social construction’ that has taken place since this approach was first introduced. He

points out that self report questionnaires were initially developed to improve the efficiency of the existing processes of screening people for different roles (e.g. in the military, employment, students etc), not as a research tool. Only later did psychologists adopt these questionnaires as a way of incorporating greater ‘quantification’ and ‘objectivity’ into their method. This allowed for the importation of the ‘experimental method’ into psychology, making it resemble a ‘hard science’. For this approach to work, measures had to demonstrate their validity and reliability, so great emphasis was placed on gathering data in controlled situations to minimise ‘interference’. Once a measure was shown to be valid and reliable, it could then be used with confidence in other settings.

What McLeod (2001a) is pointing out is that while this approach may have a lot of appeal in terms of its ‘scientific’ qualities, an over reliance on this method risks that the findings obtained from this approach are seen as the ‘only’ outcome of counselling and psychotherapy, or at least the only outcome that matters. Here McLeod refers to the critique of psychology by Danziger (1990, 1997 as cited in McLeod, 2001a), where it can be seen that intelligence becomes what can be measured by intelligence tests, that school children are taught how to pass tests rather than actually learn, and by extension, that ‘successful’ therapy becomes that which allows a client to respond to an outcome questionnaire in a similar way to some unknown ‘non-clinical’ sample. In this respect, the whole endeavour to evaluate the outcomes of counselling and psychotherapy using standardised quantitative measures can be seen as an “administratively created reality” (McLeod, 2001a p.223).

McLeod cites Danziger (1997 p.186) saying “there is a distinction... between the language used to describe a particular set of phenomena, and the phenomena themselves” (McLeod, 2001a p.223), that there is a lot more to the outcome of therapy than what can be measured on a questionnaire. Here McLeod is pointing out that currently most outcome studies and the measures they use are designed to benchmark forms of treatment rather than to investigate what ‘comes out’ of therapy. Questions such as “In what ways do people change as a consequence of participating in therapy? Are there different patterns or sequences of change? Does therapy make a difference to the course of a life? Do people who have received therapy do different things with their lives? What contribution do they make to society?” (McLeod, 2001a p.224) are not being addressed by using standardised self report questionnaires.

2.2.4 Using thermometers to weigh oranges

From a humanistic perspective, existing standardised self report measures have been criticised by Levitt et al (2005) as encompassing only a very narrow conceptualisation of change. Similar to McLeod (2001a), the authors point out that existing measures have generally been constructed in line with a medical model which historically has understood change in terms of the removal of symptoms that impede functioning. This understanding of change does not allow for the more non-linear and idiosyncratic nature of change which is posited by humanistic approaches. To highlight

this, Levitt et al (2005) compiled a list of outcome measures commonly used in humanistic research and analysed these in terms of theoretical outcome criteria. These outcome criteria were derived from a thematic analysis of humanistic literature, and included the ability of measures to allow unique, idiosyncratic responses and to report holistic rather than specific change; the inclusion of emotional response items such as greater access to feelings, increased ability to express emotions etc; interpersonal change items such as adjustment to separation, the resolution of conflict, changes to negative feelings about others etc; personal growth items such as tolerance for ambiguity, feeling creative, a sense of freedom, increased wisdom and self awareness; and the extent to which measures allowed clients to voice their concerns in their own terms and describe experiences of agency.

The results of the review highlighted that commonly used outcome measures like the SCL-90 and BDI discussed above do not assess many central goals and process of humanistic therapy. In particular, no measures allowed clients to rate change in terms of their own perception of progress of topics that were self-identified as important, and none asked directly about the client's experience of personal growth. These findings led the authors to suggest that current outcome research practices are like "using thermometers to weigh oranges" (Levitt et al., 2005. p.126) when it comes to measuring the outcomes of therapy in anything but a medicalised way. They go on to call for researchers to develop and adopt measures which are more consistent with the aims of humanistic therapies, such that there is a better fit between the therapy and the measure. With regard to the current review, this critique highlights the tendency for researchers to use measures which fit the 'administratively created reality' identified by McLeod (2001a) above. Measures which have been accepted by the research community as valid and reliable are used even though their conceptual structure does not 'fit' with what is being measured.

2.2.5 Response error

From the perspective of questionnaire design, response error is defined as the discrepancy between a theoretical 'true score' and that which is reported by a respondent (Willis, 2005). This view of error conceptualises that there is an actual 'real' value that, all things being perfect, a respondent could report with absolute accuracy. Cognitive Aspects of Survey Methodology (CASM) suggests that errors occur from underlying problems in the cognitive processes through which respondents generate their answers to the questions and statements of a questionnaire (Tourangeau, 2003). That is, people give inaccurate or unreliable answers or responses because they don't really understand the questions, can't recall the relevant information, use flawed judgement or estimation strategies, have trouble mapping their internal judgements onto one of the response items, or edit their answers in a misleading way before reporting them.

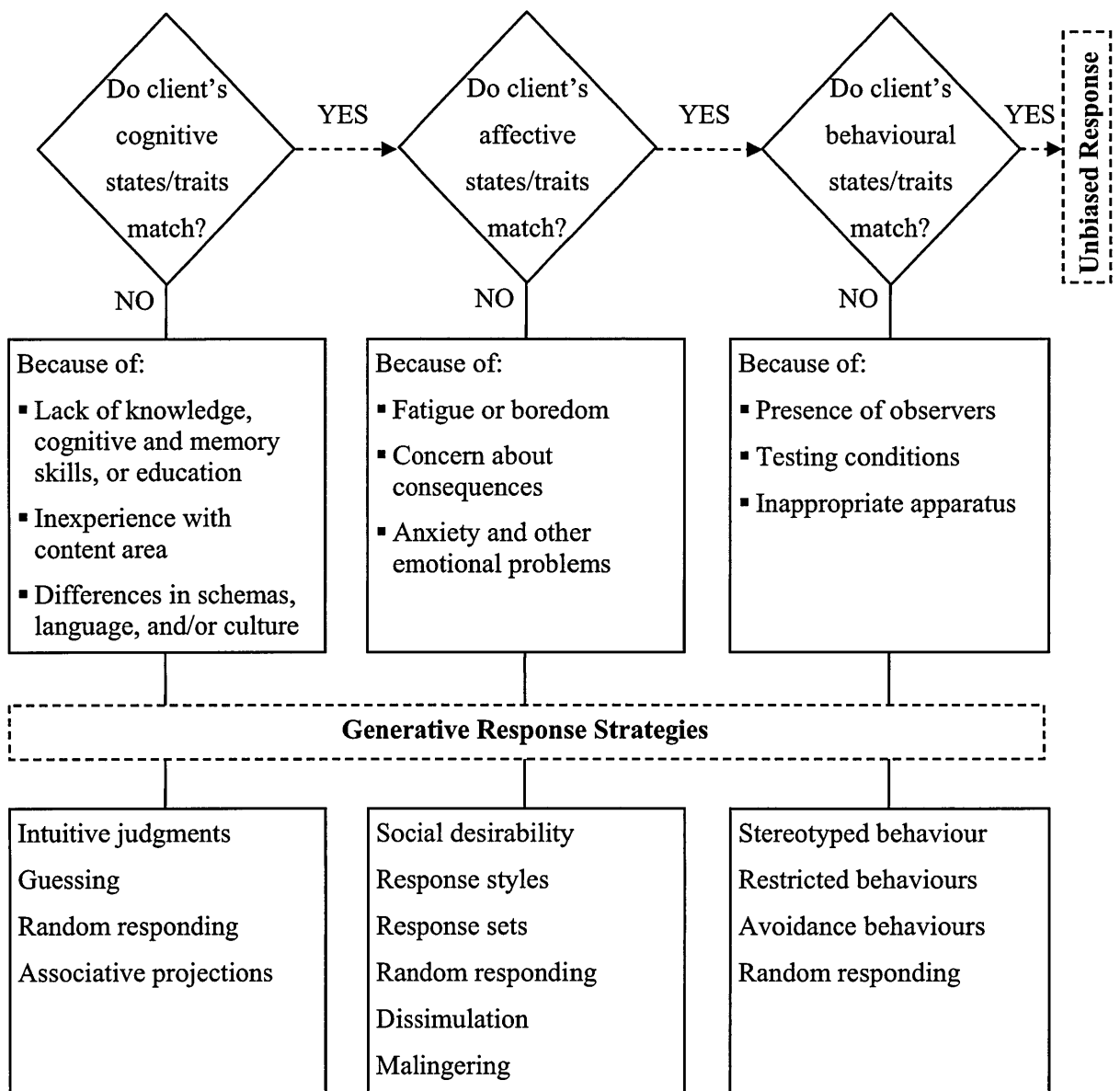


Figure 2-1 Decision tree of systematic errors for person variable (adapted from Meier, 1994 p.69)

Figure 2-1 above from Meier (1994) graphically sets out the possible sources of mismatch between a respondent and a measure, and identifies potential systematic response ‘errors’ or strategies that respondents may resort to in order to complete a questionnaire which does not match their current or general characteristics (state/trait). For example, if a client’s reading level does not allow them to fully comprehend an item, they may guess at the meaning and ‘generate’ a response rather than give a ‘true’ response. Meier highlights that when there is a significant mismatch between questionnaire items and a respondent’s cognitive characteristics (e.g. due to cultural differences), then supposedly ‘objective’ measures become more akin to projective tests containing ambiguous stimuli which result in idiosyncratic associative responses. Even when there is a cognitive match, a respondent’s emotional or affective characteristics may result in ‘generative’ responses. For example, a highly externalised client may ‘fake good’ in order to convince a researcher that counselling is working, or may respond to items in a socially desirable way in order to be accepted by the researcher. Finally, even when clients are appropriately motivated and capable of responding

honestly and accurately, their response behaviour may be influenced by external factors. For example, the presence of a researcher may distract a client, or they may feel they do not have time to think about the questions fully, or the questionnaire may not allow them to respond in a way they feel is appropriate. Only when the client’s cognitive, affective and behavioural characteristics match the measure they are completing will a ‘true’ unbiased response be achieved.

Willis (2005) proposes that the most significant source of response error is the lack of clear communication between the questionnaire designers and the respondent. Sociolinguistic analysis of conversations has revealed the complexity of everyday questions and answers. Rather than being a straightforward prompt - response model, it is revealed that normal conversation entails a forming of common ground, usually through a series of questions that clarify the initial query, such that a shared interpretation is gained. Questioners rely heavily on ‘repair mechanisms’ to put the conversation back on track when it is perceived that the initial interpretation has been inaccurate. Standardised self report questionnaires lack this ability to form a common ground of interpretation, and so it can never be certain that the responses made to the questions are actually in line with what the questionnaire designer intended.

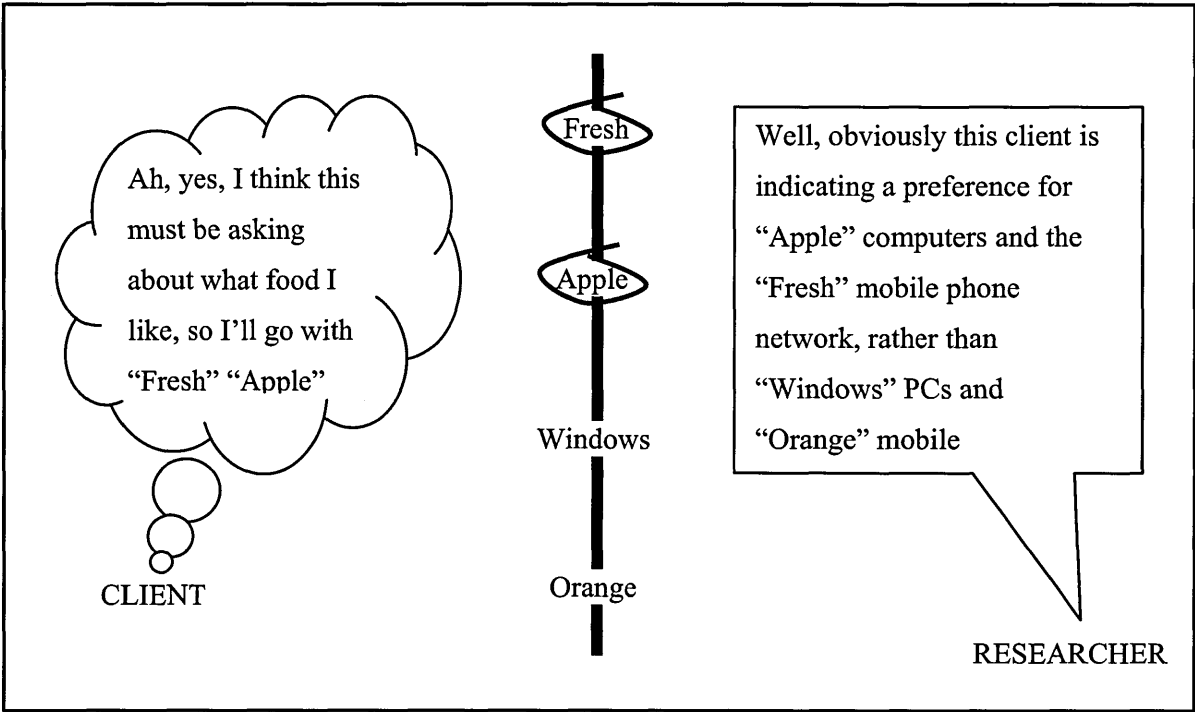


Figure 2-2 Response error as miscommunication between questionnaire designer and respondent

Additionally, Schwarz, Grayson, and Knäuper (1998) highlight the potentially problematic process for clients of determining the quantitative meaning of generally ambiguous response options. Most standardised self report questionnaires ask respondents to rate some aspect of their experience or feelings using a form of Likert scale, such as “Not at All, A little bit, Moderately, Quite a bit, Extremely” on the SCL-90, “Never, Rarely, Sometimes, Frequently, Almost Always” on the OQ-45, and “Not at all, Only Occasionally, Sometimes, Often, Most or all the time” on the CORE-OM.

This seemingly simple request is, however, extremely complex. Not only are respondents asked to determine the quantitative meaning of an ambiguous label (e.g. how often is 'rarely'), but also to quantify their own feeling or experience and map this on to it. For example, the CORE-OM question "I have been happy with the things I have done" asks a person to rate how often they have felt this way over the last week. This first requires the person conceptualise the meaning of 'happiness' for themselves (a non-trivial task in itself). Next the person is requested to connect with their experience over the last week and to identify moments that more or less approach this concept (again, a non trivial task of assessing how close a feeling is to 'happiness'). Then a person is expected to collate these variable experiences to form some sort of aggregate (does a 'little happy' count as a half compared to a 'very happy' experience?). Finally the person is required to compare their internal aggregate against the vague labels on the questionnaire (so is my '2.5' experiences of happiness 'Only Occasionally' or 'Sometime'???). Due to the complexity of this process, it is very difficult to know if the client's understanding of a questionnaire item taps the same facet of an issue and the same 'evaluative dimension' as that intended by the researcher (Schwarz, 1999).

2.2.6 Response shift and Alpha/Beta/Gamma change

Of specific concern regarding the use of self report questionnaires for measuring the outcomes of therapy, 'response shift' refers to a change in the *way* a participant responds to a questionnaire at different times. Meier (1994) points out that some aspect of the respondent is bound to be different from one occasion to the next, thereby changing *how* a person responds. With respect to counselling and psychotherapy outcome research, this is particularly problematic due to the likely effects of being in therapy. Using Meier's model of potential sources of 'response error' above, it is very likely that a client may well have experienced a change in their cognitive and/or affective characteristics as a result of being in therapy. This would hence introduce a completely different set of 'response errors' from before to after therapy. Any change registered may be more attributable to the way the questionnaire is responded to rather than a meaningful change in the person's life.

Further, McLeod (2001a) highlights that the process of therapy introduces clients to new ways of defining and making sense of their situation. He points out that therapy outcome measures are full of the terms and concepts inherent in the 'discourse' of therapy. As such, a client new to therapy may well initially answer a questionnaire with a very different understanding of what is being asked than when they have finished their counselling. For example, a person new to therapy may rate the CORE-OM item "I have thought I am to blame for my problems and difficulties" as "Not at all" because they thought that everyone else was at fault. At the end of therapy they may have come to see how their actions have affected others and rate this "Often" as a sign of taking greater responsibility for things. Here the therapeutic values of 'responsibility' and 'accountability' can be seen to have influenced the way the question is interpreted, fundamentally changing the meaning of the questionnaire item. This shift does not match at all with the intended scoring scheme for the

questionnaire which would interpret this change as a negative outcome of therapy. Similar to Meier (1994), McLeod makes the point that the potential for changes in the way questionnaire items are interpreted creates a difficulty when considering the results of outcome studies. It can never be certain that reported outcome scores are representative of actual changes in behaviour, life functioning, well-being etc, or rather are a change in the meaning attributed to questionnaire items.

The above can be seen as indicating that rather than measuring along a single, linear dimension, responses to self report questionnaires can be considered to be indicative of different types of change. Golembiewski, Billingsley and Yeager (1976) suggest that change can be conceptualised in terms of at least three distinctly different classifications: alpha, beta and gamma change. *Alpha* change is considered to occur when the meaning of the construct being measured and the psychological interpretation of the units of measurement on the outcome measure stay the same. That is, the change measured is a 'true' representation for the respondent of the actual change that has occurred for them. Here the measure is acting as a standard 'ruler'. On the other hand, *beta* change occurs when the meaning of the construct being measured stays the same, but the psychological interpretation of the units of measurement changes. For example, the respondent uses a different set of criteria to rate the intensity of distress after therapy than before. Here the change measured is either an under representation or over representation of the actual change that has occurred for the respondent. In this instance, the measure is now acting like a 'rubber ruler' which has stretched or compressed from one reading to the next. Finally, *gamma* change involves a 'quantum shift' – a redefinition or reconceptualisation of the 'psychological space' for the respondent. This is a major change in the perspective or frame of reference within which the phenomena are perceived such that the previous meaning of the 'measurement' becomes irrelevant. The example above of the change in understanding of the CORE-OM item "I have thought I am to blame for my problems and difficulties" would be representative of this gamma change. Here the measure is no longer acting as a 'ruler' at all, but more like a projective test, where responses need to be 'interpreted' rather than 'calculated' (Semeonoff, 1976).

The problem for outcome measurement from Golembiewski et al's (1976) perspective is that standardised quantitative questionnaires are typically designed purely to report alpha change – i.e. a change in the mean score of a measure from before to after therapy. There is an assumption of linearity between responses made before therapy versus responses made after therapy. If responses show a significant change from before until after therapy then it is assumed that 'real' change has occurred, rather than just a recalibration of the measurement dimension as in beta change. Conversely, if no change is measured in responses then it is assumed that no 'real' change has occurred, rather than the possibility of a radical reconceptualisation of a problem such as with gamma change. For example, at the beginning of therapy an individual may rate the OQ-45 item "I find my work/school satisfying" as "Rarely" because they feel depressed, but at the end of therapy they may again rate this item "Rarely" because they now realise that the work they are doing is not

for them and are looking for a new job. Hence this 'no change' score hides a fundamental, positive outcome for the individual which does not get reflected in their item response. Especially for counselling and psychotherapy where gamma change may well be a desirable outcome of therapy, this would seem a fundamentally limiting aspect in terms of gaining meaningful research data.

Golembiewski et al (1976) suggest that using factor analysis, it may be possible to detect gamma change by looking at the patterns of responses, or the 'factor structure' of a multi item measure from before to after an intervention. Extending this, Chan (2003) identifies that longitudinal factor analysis (LFA) can be used to discern if the same construct is being measured over time, and with the same precision. According to Chan, alpha change can be calculated only if there is 'measurement invariance' across time, such that "each time point has the same number of factors... with the same specific items loading on each factor (...configural invariance) *and* the factor loadings corresponding to the identical items are equal across time points (...factorial invariance)" (p.354). Further, Chan proposes that using multiple indicator latent growth modelling (MLGM), it is possible to identify and partition reliable variance of latent factors into common (construct) variance and unique variance. This approach offers a method for analysing response data which does not assume simple linearity, and goes some way to resolving issues of response shift. However, a significant issue remains in terms of a measure's ability to 'tap into' dimensions of change that may have occurred due to the 'quantum shift' in a participant's frame of reference (Norman & Parker, 1996). Indeed it is entirely possible that the quality of change engendered in a transformative therapeutic experience may not be amenable to being captured in a quantitative format at all.

2.2.7 Reactive effects and demand characteristics

A further critique of self-report questionnaires is that rather than being a passive measure of some aspect of a respondent, the items of a questionnaire actually alter what is being measured (Meier, 1994). These 'reactive effects' are demonstrated in a study by Strack, Schwarz, and Gschneidinger (1985) where it was found that the framing of questions had a direct impact on how respondents rated their current level of happiness and life satisfaction. When respondents were first asked to report either *positive* or *negative* life-events that had *recently* happened to them, they *assimilated* this information into the report of how happy they currently were. Respondents who recalled recent positive events rated themselves happier than respondents who recalled recent negative events. In comparison, when respondents were first asked to report either positive or negative life-events that had happened to them in the *past* (at least five years ago), they *contrasted* this to their current situation to report how happy they were. Respondents reported lower current happiness after recalling past positive events than after recalling past negative events. This can be understood in terms of past events being used to form a mental representation of the standard against which

respondents evaluated their current lives. Compared with the problems and issues (or fun and happiness) they had five years ago, life now seemed pretty good (or rather dull, respectively).

Similarly, Meier (2008) refers to a review by Bailey and Bhagat (1987) which highlights that the act of completing questionnaires can create or alter the level of held beliefs and attitudes. For example, in a study where participants were randomly assigned to two groups, one asked about cancer, and the other about crime, no significant difference was initially found in their attitudes. However, on retest several weeks later, the participants asked about cancer showed a significant increase in their assessment of the importance of good health. Here the act of completing the questionnaire gave the participants something to think about resulting in a measurable change in attitude. Similarly, counselling outcome measures have the same potential to alter the individual's psychological state. For example, a deeply unhappy person on reading through the CORE-OM questionnaire may come across the question "I have thought it would be better if I were dead" and realise, no, actually, things are not that bad after all. From this perspective, self report questionnaires are no longer passive 'receivers' of information, but active 'lenses' that shape how participants see themselves.

In addition to potential reactive effects of the actual questionnaire, the whole process of being involved in a study may also possess 'demand characteristics' which shape a person's responses (Orne, 1962). For example, a participant may perceive the process of completing a questionnaire as a test or exam in which they must prove themselves, or an ordeal or trial that must be endured, or a payment in order to receive therapy, or an altruistic act in order to help others. These differing perceptions may well have a significant influence on how an individual responds. For example, an altruistic person completing a questionnaire at the end of therapy is likely to be well aware of the implications for the study, and may actively minimise their reporting of problems and difficulties in order to 'help out' the study results. Indeed Orne hypothesises that participants in studies actively seek out the intentions and aims of the research using cues such as recruitment material, information and consent forms, published information, subtle interactions with the researcher, and even the research instruments (such as questionnaires) in order to discern how to be a 'good subject'. Further, Orne contends that demand characteristics may well significantly contribute to any 'results' obtained from studies, independent of the actual 'intervention'.

Orne's (1962) hypothesis would seem to be borne out in a study of the ecology of psychotherapy research by Anderson and Strupp (1996). The study was constructed around a test of the effect on outcome of additional training in time-limited dynamic psychotherapy (TLDP). Clients who were judged highly aware of their role as 'subjects' in the study seemed to be more directly affected by the primary objectives of the research project compared to clients who reported a low awareness of their subject role. The 'high subject role' participants who received therapy from therapists trained in TLDP reported better outcomes, with many attributing this to the benefits of being in the

research. In stark contrast, ‘high subject role’ participants who received therapy from ‘control’ therapists who had not been trained in TLDP reported worse outcomes, along with feelings of being manipulated and ‘used’. From the results of their study, Anderson and Strupp suggest that demand characteristics constitute a complex set of interpersonal interactions and expectancies between participants, therapists, and researchers which can have a significant impact on the outcomes of a study.

This suggests that the awareness and experience of being part of a research project, including the act of completing self report questionnaires, will not only affect the measured results, but will also have a direct affect on the actual client. For example, the intent to be a ‘good subject’ may result in greater motivation to ‘get better’, the items on a questionnaire may direct a person’s attention to what needs to change in order ‘improve’, or a single statement may help a person to ‘put things into perspective’. Conversely, if a participant feels they are being manipulated, or that they are being a ‘bad subject’, or feel that they don’t ‘measure up’ on a questionnaire, they may feel even more down and dejected from their experience of participating. This highlights that the whole *social ecology* of being involved in outcomes research is not a neutral event, but an active, social task (McLeod, 2001a).

Though reactive effects and demand characteristics are not limited to outcomes research using standardised self report questionnaires, these effects do severely compromise the philosophical foundations upon which the argument for such things as questionnaire reliability and validity are based. Even more significantly, however, it calls into question the sorts of things that ‘come out’ of therapy research. If we accept that the measures we use and the way we use them will always have an effect on participants, a question arises as to what we want that effect to be. Once the illusion of ‘neutrality’ is given up, there would also seem to be an ethical responsibility to consider how a study ‘co-constructs’ a participant’s experience. This presents an opportunity to intentionally construct and conduct counselling and psychotherapy outcome studies in a more collaborate, enabling manner, which openly acknowledges and embraces the participant as a valuable co-creator of the research (Anderson & Strupp, 1996).

2.2.8 Issues of power and the loss of the individual client’s voice

Following from the above, perhaps the most significant issue with traditional quantitative methods in counselling and psychotherapy outcome research is the subtle reinforcement of power differences and the silencing of the client’s voice. McLeod (2001c) highlights that the typical rhetoric of quantitative outcome studies is power, control and silenced voices. Within such studies, questionnaires are typically ‘administered to’ a ‘subject’ and then scored by an ‘expert’ who has the knowledge to interpret, and pronounce judgement on the meaning of the results. Further, the researcher then becomes the ‘author’ of the published results, with the individual participants

reduced to anonymous numbers, if present at all. Through this process, the client's voice is completely lost, to be replaced by that of the researcher who gains acknowledgement and credibility. Indeed, it could be argued that the greater the number of clients silenced (the larger the 'n'), the more 'credible' the researcher's voice becomes.

Hughes (1995) has conceptualised how this 'scientific process' reinforces differences between the dominant group and 'others'. Differences are *named* by the dominant group as being worthy of investigation (e.g. mental health versus well being, social functioning versus social exclusion etc). Once something is named, it is then *quantified* such that it can be measured. This quantification creates the illusion that subjectivity and politics have been transcended, that the 'numbers' equate to 'objectivity', and this objectivity is valued because it is perceived to be value free. *Statistical analysis* further enhances claims to objectivity, whereby the researcher is seen to employ a 'neutral' method such that what emerges from the analysis is considered an unbiased 'fact'. This process leads to the *reification* of the initial abstract concepts into concrete 'knowledge' which can be used to segregate and classify, as well as forming the basis for social, political and economic decisions and judgements. The culmination of this process is *objectification*, whereby something subjective is turned into an object, a 'thing' which is 'other'. Hence in counselling and psychotherapy, concepts such as 'depression' and 'anxiety' become tangible, measurable 'things' which can become the target of 'interventions'. Further, people are seen as 'depressed' or 'anxious' and hence less 'able', in need of help to become 'normal'.

This process can be seen as imbedded in the construction and use of standardised self report outcome measures in counselling and psychotherapy. Typically, some concept is *named* as being worthy and in need of measurement (e.g. depression, anxiety, etc). Next, 'experts' are consulted in order to generate items that are considered to *quantify* the relevant concepts. These items are then 'tested' and *statistically analysed* to establish their reliability and validity. Once statistically validated, an outcome measure becomes *reified* such that it is seen to be 'proven', beyond question, the source of indisputable evidence. Finally, the 'score' of a questionnaire comes to represent and *objectify* that which is being measured. Similar to the critique by McLeod (2001a) above, 'depression' becomes what is measured on the BDI, 'psychological distress' is defined as a score of 10 or more on the CORE-OM. Here, the complex, subjective, multi dimensional, unique experience of a person is reduced to that which can be measured. The individual client's self perceptions are filtered and edited such that only that which coincides with the items on the questionnaire are 'heard'. After being aggregated and 'averaged', a single, 'pure' number is obtained, free from the murky subjectivity and uncertainties of the raw human experience. This process effectively 'sanitises' the individual client responses such that any semblance of a meaningful, human interaction is completely erased; the client's voice is effectively depersonalised, dehumanised and eventually lost all together.

2.2.9 *Nomothetic versus idiographic measurement*

The problems with self report outcome measures identified above can be seen as stemming from the traditional focus of psychological measurement on group differences and changes rather than the individual. Meier (1994) highlights that this ‘nomothetic’ approach to outcome measurement focuses on attributes and characteristics that are considered to be relatively stable and common to all people. The assumption here is that as long as results are aggregated over a large enough group of people, measurement errors will balance or cancel each other out, such that individual inconsistencies become irrelevant. Researchers can then state with varying levels of confidence that any difference measured is a true measure of the ‘real’ difference. The greater the number of participants, the greater the confidence is that the differences are not due to chance or measurement error alone. Hence this approach to measurement effectively interprets individual inconsistencies as ‘error’ which needs to be negated in some way (Meier, 2008).

In contrast, Allport (1937) defined idiographic research as being interested in patterns of change *within* an individual over time, within the context of the person’s life. From an idiographic perspective, systematic measurement errors occur when an outcome measure assumes a consistency across individuals which is not present (Meier, 1994). For example, in the SCL-90 the statement “Feeling that most people cannot be trusted” is intended as a universal measure of paranoia. However, for an illegal immigrant caught up in the criminal underworld, a response of “Extremely” may be a healthy indicator of self preservation rather than any sign of paranoia. Similarly, CORE-OM’s item “I have achieved the things I wanted to” may be intended as a positive gauge of a person’s ability to function satisfactorily, but a score of ‘not at all’ may be most ‘healthy’ for a young achiever just beginning their first job. These examples highlight the potential for standardised questionnaires to ‘miss’ the individual, and bring into question the assumption of consistency.

These issues highlight the limits of a traditional nomothetic approach to measurement, leading Meier (2008) to suggest that “employing traditional tests to measure counseling outcome may be akin to eating soup with a fork” (p. 169). Here, Meier is alluding to the effect of focusing on a limited set of standardised, stable constructs means that the richness of individual, idiosyncratic change is never sufficiently captured. An ideographic approach to measurement attempts to fill some of the holes left by nomothetic approaches. Rather than using measures valid across groups of individuals, the idiographic approach to validity focuses on what is meaningful and valid to a particular individual. Instead of being a distanced, disconnected process, measurement is seen as being an integrated part of the intervention. Further, it is acknowledged that “assessment occurs in the context of a relationship between assessor and individual” (Meier, 2008 p.199). Only within this ‘real’ relationship is a greater understanding of the interaction between the client, the therapy, the research, and the client’s life situation possible, along with how this changes over time.

2.3 Part 2: An alternative approach - Qualitative self report outcome data collection methods

The previous section highlights the many issues that can be considered to be inherent with traditional quantitative self report questionnaires. From the philosophical concerns posed by Mischell (1997; 2000) and Slife (2004) through to the more practical limitations highlighted by Meier (1994; 2008), it can be argued that this traditional approach to outcome measurement has reached its limits in terms of expanding our understanding of the outcomes of counselling and psychotherapy (McLeod, 2001a). Slife (2004) proposes that an alternative approach to therapy research could be informed by continental philosophy and qualitative research methods. Rather than imposing structure onto and manipulating the data, a qualitative approach invites researchers to come into a much more intimate relationship with the data - “the interpreter is not so much applying a method to the text as an observed object, but rather trying to adjust his own thinking to the text” (Palmer, 1969, p. 236 as cited in Slife, 2004 p.52). This reframing of the research task can be seen as an attempt to honour the client’s perspective more fully, and to genuinely ‘enquire into’ and discover from this what ‘comes out’ of therapy for an individual (McLeod, 2000b). Further, Slife suggests that we need a change in orientation of therapy outcome research to look not just at ‘feeling better’, but to include more existential dimensions such as ‘having more purpose’, ‘understand things more’, or ‘helping others’. Similarly, there is a need to ‘contextualise’ people within their lived world rather than attempt to examine them as isolated individuals. Persons should be considered as inherently interdependent, ‘radically social’ beings who derive their identities from others (individuals, community, culture) and the roles they play. Finally, instead of absolutes, researchers could look for contextual patterns of change in experiences, meanings, relationships etc. This approach would not try to discover universal truths or theoretical principles that underlie the client’s behaviours and experiences, but would attempt to understand the particular meanings of change for an individual.

Similarly, McLeod (2001b) contends that researchers need to conduct research which is more consistent with the practices and values of counselling and psychotherapy. This might include attending to the idea of human agency, collaborative and dialogical forms of meaning-making, the importance of feeling and emotion, the role of language in constructing realities, the capacity for reflexive self-monitoring, the validity of sacred experience etc. With respect to qualitative outcome research, McLeod (2000b) identified a number of key points that have emerged from existing studies which show the potential for this approach:

- Clients possess their own criteria for evaluating therapy.
- Clients are able to discriminate between effective and ineffective therapies.
- Clients are able to differentiate between change attributed to therapy and change attributed to

other life factors.

- Higher rates of negative/harmful therapy experiences are recorded, compared to other studies.
- The client's criteria for evaluating the effectiveness of a therapy episode depends on where that episode fits in to their life course.
- Client perceptions of therapy outcome are grounded in their implicit theories of personality.

Qualitative, self report outcome data collection methods can be seen as a loose grouping of approaches with the potential to explore the richness and diversity of individual client change. Rather than attempt to identify change using discrete, predetermined quantifications of a client's problems or symptoms, or basing outcomes assessment on some externally defined criteria, these approaches attempt to access the client's own internal frame of reference regarding the changes that have occurred for them over the duration of therapy. They offer clients an opportunity to express the changes that have taken place for them in a more expansive, open ended form than traditional quantitative self report outcome measures, providing researchers with a rich, in depth narrative about individual change. Typically, qualitative self report methods use a number of prompts which a respondent is then more or less free to respond to in a way which is most meaningful to them. This approach can offer an opportunity for people to 'voice' different aspects or dimensions of the outcome of therapy which were personally significant to them, rather than being confined to a limited set of criteria predefined by the researcher.

For his review, McLeod (2000b) was able to locate only six published qualitative outcome studies. Since that time, numerous other qualitative studies that investigate the outcomes of therapy from various perspectives have been published. Further, the use of qualitative methods has become more widely used in Masters level counselling training programmes. In addition, a number of studies not included in McLeod's review have been identified. Rather than attempt a comprehensive review of the *findings* of individual papers, this review will identify and discuss the different *types* of qualitative data collection methods used in various therapy outcome studies to date (McLeod, 2000a). Further, the potential for other qualitative data collection methods not currently utilised in therapy outcome research will be discussed. Similar to the review of quantitative measures above, the aim is to construct a typology of qualitative, self report methods. However, unlike quantitative measures which are typically branded and specifically named (e.g. MMPI, BDI, SCL-90 etc), qualitative methods tend to be more a loose grouping of similar techniques. As such, rather than identify specific elements of individual name brand methods, the review will focus more on the general features of the methods identified, with some examples of studies that have utilised them where available.

The intention here is to highlight the variety of approaches that qualitative researchers can employ to collect data from participants about the outcomes of therapy. Additionally, the appropriateness of each approach for investigating the outcomes of counselling and psychotherapy from the

perspective of the individual client who is participating in the study will be discussed. Note that the data collection method has been taken as distinct from the study design. For example, a case study design could employ both quantitative and qualitative methods for a single client, whereas a longitudinal design could use the same methods in a different way. Further, the review will focus on self report methods rather than other sources of qualitative data such as therapist's notes, observational data, or interviews with significant others.

2.3.1 Qualitative post-therapy questionnaires

The simplest approach to collecting qualitative self report outcome data is the use of questionnaires that include some form of open response questions which allow respondents to reply more fully than in the pre determined format of purely quantitative questionnaires. As this type of questionnaire is relatively simple to construct and cost effective to implement, this approach is regularly used by counselling agencies to gain an indicator of the level of 'customer satisfaction' with their service. For example, a questionnaire may ask a client to rate their overall level of satisfaction with the counselling on a five point Likert scale (e.g. Very dissatisfied, Mostly dissatisfied, Neither satisfied nor dissatisfied, Mostly satisfied, Very satisfied) and then ask them to say what they were most satisfied with, and least satisfied with. This type of questionnaire yields both quantitative data (e.g. 80% of respondents were 'mostly satisfied' or above) along with qualitative descriptive data. Unlike quantitative data, this qualitative data needs further processing before it can be statistically analysed. For example, responses to a question might be coded in order to identify commonly occurring themes, or rated by researchers on how much a response resembles a predefined criteria. Additionally, the qualitative responses may be used verbatim to enhance and supplement the quantitative results.

An example of a published study which incorporated qualitative questions alongside more conventional outcome indicators is that by Bende and Crossley (2000). Their study requested feedback from 29 past clients on various aspects of their counselling experience. The data received from this study provided the researchers with valuable feedback on the counselling that was provided, with clients making several comments on how the service could be improved. Significantly, the authors reported that though some respondents did not seem to make significant improvements according to the quantitative outcome data, the more qualitative data from the open format questions indicated that changes had occurred, and were ongoing. It would seem from this that clients were able to give a more complete picture of the outcomes of therapy using both the qualitative questions and the conventional outcome indicators than from the standardised outcome evaluation data alone. From the individual client's perspective, the more 'common sense' and open ended style questions may provide a greater opportunity to feedback the 'everyday' impact of counselling and psychotherapy compared to the use of standardised outcome measures.

Due to the lack of standardised response items, however, this approach to measuring the outcome of therapy is seen to lack in empirical validity from a quantitative perspective. Similarly, the lack of space and flexibility for qualitative responses make this approach of limited use for in depth qualitative investigations into the outcomes of therapy. As such, this method is rarely reported in published research. Indeed, the article by Bende and Crossley cited above was a rare example of the method being used in published research. Their approach of combining more open ended response questions with standardised outcome indicators would seem a good way of gaining some empirical validity whilst giving clients at least a minimal opportunity of having a 'voice' about their experience of therapy.

A further significant limitation of this approach to researching the outcomes of therapy is the reliance on retrospective recall of the changes that have occurred from before until after counselling. Especially for studies conducted in real world settings where therapy may last over several months, if not a number of years, accurately recalling how life was like before therapy began may be quite problematic. In these instances, the method places a heavy burden of responsibility on the participant to try to recall what life was like before therapy, and to differentiate what changes may have come about through therapy rather than other life events. Further, the actual process of therapy may well alter the participant's fundamental view of themselves and their world, such that recalling life before therapy is like looking at a different person.

These limitations suggest that using qualitative post-therapy questionnaires, while relatively convenient for the researcher, have limited value for exploring the richness and diversity of individual client change. They would appear to be a useful adjunct to traditional standardised outcome measures, offering an opportunity to gather at least a minimal amount of qualitative data in parallel with quantified outcome scores. However, used on their own they lack both quantitative and qualitative validity, falling into a 'no mans land' between the two approaches.

2.3.2 Idiosyncratic post-therapy qualitative interviews

The most generic approach to collecting data on the outcomes of therapy using qualitative methods is the use of post-therapy interviews which are unique to a particular study. This type of study typically involves the researcher interviewing clients at some period after the completion of therapy using a semi-structured interview schedule designed by the researcher to elicit responses appropriate to the aims of the particular study. Typically, interviews are recorded and transcribed, then analysed using some form of thematic analysis (such as grounded theory analysis) in order to identify common themes across the interviews in relation to the research question.

An example of this approach from McLeod's (2000b) review is a study by Howe (1989) to evaluate the effectiveness of a family therapy practice. Rather than measure whether the participant's presenting problems had been 'cured' in an objective, quantifiable way, Howe's interest was to determine whether or not the participants *felt* they had been helped (Howe, 1996). To achieve this, Howe interviewed members of each family as a group 4 to 8 weeks after the end of their final therapy session. Interviews, lasting from two to three hours, consisted of a series of broad, open-ended questions and prompts to encourage participants to talk about whether or not they felt they had been helped. Transcripts from the interviews were analysed using a grounded theory approach to identify emergent themes across all the interviews. Significantly, of the twenty-two families who received therapy, only five reported they had gained from it. A further five were ambivalent about their experience, and twelve families were critical or dismissive of therapy. These quite striking 'results' gave a very different measure of the effectiveness of the therapy practice from what would usually be expected from a quantitative outcome study (Rodgers, 2003).

In another study of this type, Rodgers (2002) conducted retrospective interviews with nine clients, 3 to 4 months after they had completed therapy. The aim of the study was to explore the participants' own perceptions of therapy, in order to gain a better understanding of what clients perceive as the most significant aspects of their counselling. Interviews, lasting between 45 and 90 minutes, asked participants to relate how they were feeling before they came to counselling, their experience of counselling and what was helpful or difficult about it, about any changes that the person had noticed in their personal, work or social life, and whether or not they felt these changes were related to their counselling. Similar to Howe, interviews were recorded and analysed using a form of grounded theory in order to discover common themes across all participants. Results from the study suggested a set of 'common requirements' for therapy to be effective: *permission* to speak freely and honestly; to feel *engaged* both with self and with the counsellor; to have a sense of *transparency*, such that they are 'seen fully' by the counsellor, and by themselves; and to undergo a process of *restructuring*, such that things are perceived or experienced from a different perspective. In his discussion, Rodgers suggests that the degree to which an experience of therapy is perceived to meet each of these 'common requirements' can be seen as an indicator of the level effectiveness of therapy.

McLeod (2000b) points out that this type of study demonstrates that clients possess their own criteria for evaluating therapy, that clients are able to differentiate between change attributed to therapy and change attributed to other life factors, and that it is possible to make, with confidence, statements of success/failure on the basis of qualitative data. Additionally, Rodgers (2003) argues that this approach to researching the outcomes of therapy not only yields interesting results, but also allows researchers to identify the reasons behind the results. For example, in the study by Howe above, researchers were able to identify a number of specific reasons for clients' discontent, which then allowed actual changes in practice to be implemented. As such, studies that utilise this

method offer the opportunity to provide practitioners with valuable feedback into how their practice is actually being received by clients, what is being experienced as helpful or hindering, and what really made a difference *in practice* rather than in theory.

With regard to collecting data on the outcome of therapy from the individual's perspective, this approach offers participants the opportunity to express in detail their retrospective reflections on the significance of the changes from before until after counselling. Further, the researcher is able to dialogue with participants in order check out their understanding, and to explore things at greater depth. This offers the potential for a rich set of results which more fully capture each individual's experience as compared to a predefined set of questions in a quantitative questionnaire. It offers a method where the nuances and subtleties of change can be explored rather than a participant being required to fit themselves into a predefined 'box'. It also offers a client the opportunity to reflect on and consolidate any changes that may have occurred during therapy, and to identify any areas that may still need attending to, and as such has the potential to be 'therapeutic' in its own right.

Though this method offers a promising alternative to purely quantitative approaches to measuring outcomes of therapy, the approach has a number of limitations with regard to investigating the client's perception of the outcomes of therapy. Similar to qualitative questionnaires, the reliance on people's retrospective recall of the changes that have occurred from before until after counselling may significantly distort the perceived outcomes of therapy. In addition, this method is also limited by the idiosyncratic nature of the design. Studies are typically designed to explore a research question of interest to the researcher, rather than to specifically explore the client's own perception of the outcomes of therapy. As such, this method is highly dependent on the aims of the researcher and the style of qualitative interviewing. The researcher will usually inform the participant of the aims of the study before hand, and have a set of questions designed to match their central research question. Even though different researchers may be more or less open to allowing participants to talk in detail about their own perception of the outcomes of therapy, the researcher will always have an agenda to have their own questions answered. This factor also comes into play in the analysis of the interviews. As a matter of necessity, all thematic analysis entails a reduction of data across interviews. This data reduction is highly dependent on the interests of the researcher, on what they extract from the interview as significant or interesting with respect to their research question. These factors inherently shift the focus of a study towards the researcher's perspective and away from the client's. This effectively means the participant's experience is 'filtered' by the researcher, such that only those aspects of a person's experience that are aligned with the underlying research question are taken into account. Other potentially significant aspects of 'outcome' may well be discarded as irrelevant to the researcher's study.

Overall, this approach to qualitative data collection offers the potential to provide interesting insights into aspects of participants' experiences of therapy. However, the tendency would appear

to be that each study typically has a unique aim and accompanying set of research questions, and each researcher usually employs a slightly different form of thematic analysis. Though this approach offers a rich diversity of results and can give us a detailed insight into different aspects of therapy, the overall ‘picture’ does not have a lot of coherency. Studies do not usually build directly on the work of others, or use research questions that are comparable to each other. Each researcher typically follows their own interests, resulting in a fragmented field of studies that are difficult to interpret in any unified way (McLeod, 2001c). Though it can be argued that this approach contributes to ‘local knowledge’ specific to the individual setting and context of each study (McLeod, 1999) it also contributes to their relative lack of influence on standards and guidelines for practice. This brings into question the ethics of conducting research that may be more for the benefit of the researcher alone than any wider influence.

2.3.3 Standardised, semi structured change interviews (Client Change Interview)

An approach to qualitative outcome data collection that attempts to provide a more structured method for evaluating the client’s perception of the outcomes of counselling and psychotherapy is the use of standardised semi-structured change interviews. Here the approach taken is not so much to ask questions about a specific research topic, but rather to collect a general set of qualitative data that can be used in various ways.

The Client Change Interview (Elliott, 1999) is a good example of this approach to qualitative outcome data collection. It is a 60 to 90 minute interview that can be administered at the end of therapy and at regular intervals throughout therapy. The interview questions attempt to explore the changes that a person has noticed since therapy began, what the person attributes these changes to, and helpful and unhelpful aspects of therapy. Specifically, in the original version of the interview (Elliott, 1996), clients are asked to identify half a dozen or so changes that they have noticed, including any changes for the worse. The client is prompted to consider changes in thoughts, feelings, actions, or ideas that have come to the person, or been brought to their awareness from others. The client is then asked to rate each of these changes according to how expected versus surprised they were by it, how likely versus unlikely that the change would have occurred without therapy, and how important or significant the change was for the person. The interview schedule then goes on to ask the person what they think has caused the various changes, including things both outside and within therapy. Finally, the client is asked to consider what has been helpful about therapy, and what kind of things about their therapy were hindering, unhelpful, negative or disappointing for them. In the revised version of the interview (Elliott, 2004), clients are also asked about what resources, either personal strengths or things in their life situation, that they feel have helped them to make use of the therapy, as well as any limitations, either personal weaknesses or difficulties in their life situation, that have made it harder for them to make use of therapy. The

latest version of this instrument (Elliott & Rodgers, 2008) adds questions about what it was like to be involved in the research, including what has been helpful about the research, and anything hindering, unhelpful, negative or that got in the way of therapy.

An example of a study which uses this approach is a social anxiety research project being conducted by Elliott and colleagues (Elliott, 2007a). As part of this therapy development protocol, clients are interviewed after eight sessions of therapy to explore the changes that they have experienced so far, and to discuss what has been helpful and hindering about the counselling, and the research. After the end of therapy (20 sessions) clients are again interviewed, as well as at six month and 18 month follow-up. So far, this approach has allowed the researchers to develop some tentative insights into the processes and outcomes of person-centred and experiential therapy for social anxiety. Of particular interest in terms of outcomes, the Client Change Interview is conducted in parallel with a battery of quantitative outcome measures such as the CORE-OM (CORE System Group, 1998) discussed above, the Social Phobia Inventory (Connor et al., 2000), the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), etc. In particular, this mixed method approach has allowed detailed single case analysis to be presented in the form of Hermeneutic Single Case Efficacy Design (HSCED, see Elliott, 2002), offering both objective and subject contributions to judgements of the ‘success’ or ‘failure’ of cases (e.g. Cornforth & Freire, 2009).

This approach to qualitative research allows a standard set of data to be collected at different stages of therapy. By undertaking interviews at various mid therapy points, the problem of retrospective recall is reduced as participants are asked to recall changes over shorter durations compared to post-therapy outcome interviews alone. Further, the interview schedule specifically focuses on the participant’s attributions of any changes, allowing for change factors out with therapy to be differentiated from those within therapy. Additionally, the questions on the resources and limitations of a person’s life situation allow a more contextualised view of therapy outcomes to be obtained. This broad spectrum approach potentially offers participants more opportunity to ‘tell their story’ compared to interview schedules which focus on a specific research question, as is usually the case with idiosyncratic post-therapy studies.

A further benefit of this structured approach is that it allows similar information to be obtained across different clients, across different settings, and potentially across different cultures. The potential here is that comparative studies could be undertaken across quite disparate research projects, for example comparing the commonality and difference between a North American university setting and a German outpatient clinic. The key point here is that the structured approach offers the opportunity for researchers to utilise the data in different ways at different times, rather than being restricted to a single study intended to answer a specific research question such as with idiosyncratic qualitative interviews. Researchers can effectively ‘recycle’ the collected

data from one study to the next, rather than it going to waste once a study is completed. Additionally, later researchers can retrospectively ‘mine’ the data for their specific research interests. This ‘reusability’ factor offers a significant benefit particularly for settings such as university research clinics whereby a large number of researchers can utilise a shared ‘data collective’ rather than needing to recruit participants individually.

A potential concern for clients participating in such studies, however, is the very longevity of the data archive that makes it advantageous to researchers. Rather than the data collected being used for a specific purpose and then destroyed, it may instead be archived and reused for purposes very different from those proposed in the original research study where the data was collected. Careful attention to wording of information sheets and consent forms would seem essential to ensure that participants have sufficient understanding of the consequences of their participation. However, even the most diligent of consent processes can not allow for the unknown of the future. What may have been fine for a participant to express during the initial research interview may take on a very different significance and meaning at a later date. The general consent given previously with good intentions may become obsolete and invalid from the participant’s perspective in years to come. Hence it would seem important to implement ethical practices such as requiring future researchers to seek explicit additional consent for further uses of the collected data.

A further potential limitation of this approach from the client’s perspective concerns the use of mid therapy change interviews during the actual counselling process. While beneficial from the research perspective in terms of not relying completely on post-therapy retrospective recall, mid therapy interviews have the potential to disrupt the therapeutic process, not only in terms of the time taken to arrange and conduct the actual interview, but also in the form of engagement between the researcher and the client. Rather than being a neutral event, the research interview may construct or alter expectations of the therapy or the therapist, or directly affect the content of future sessions. For example, after experiencing a structured research interview approach, a client may wish their therapist to become more structured in the therapy sessions. Alternatively, a participant may have had a difficult experience with their researcher and request time during therapy sessions to process what went on. Whilst these events may have the potential to enhance the therapeutic process, they may also act as a distraction from the original intent that a client had when entering therapy.

2.3.4 Pre-Post therapy qualitative interviews (Narrative Assessment Interview)

A qualitative approach to investigating the outcomes of therapy which attempts to avoid the limitations of relying on client’s retrospective recall is to conduct interviews at the beginning of therapy and to compare these along certain criteria to interviews conducted after therapy is

completed. This approach differs from the standardised, semi structured interview approach taken with the Client Change Interview in that the content of the pre-therapy interviews can be actively used in the post-therapy interview as a point of reference for the participant.

The Narrative Assessment Interview (NAI) is one such method that attempts to assess the outcomes of therapy in terms of changes in the client's macro narrative or self story (Hardtke & Angus, 2004). The interview protocol consists of three stages: a brief, semi structured interview conducted after the first session of therapy; a summarising of the main aspects of the interview; and a post-therapy reflection interview. The first stage interview is intended to be a collaborative exploration of clients' stories about themselves and the views they hold about others' perceptions of them. To facilitate this exploration, three questions are asked: "How would you describe yourself?", "How would someone who knows you really well describe you?" and "If you could change something about who you are, what would you change?". The first two questions are accompanied by an empathic exploration of what emerges, along with a request for recent examples from the person's life to illustrate the points raised. The final question is intended to gain an understanding of what the client hopes to change over the course of therapy, and to provide a concrete pre-therapy reference point for the participant to reflect upon at the end of therapy. In the second stage of the protocol, the recording of the initial interview is comprehensively summarised by the researcher to provide a written record of key descriptors in the form of the Narrative Interview Summary Sheet. During the final post-therapy interview stage of the protocol, clients are asked to read and critically reflect upon the summary of their initial research interview, in order to facilitate a critical inquiry into their experiences of any change during therapy.

The theory behind the Narrative Assessment Interview has been derived directly from extensive process research into how client's self-stories change in therapy (Angus & Hardtke, 1994; Angus, Levitt, & Hardtke, 1999). This research revealed that clients who experienced positive outcomes seemed to make meaning of their experiences by exploring personal expectations, needs, motivations, anticipations, and beliefs of both the self and 'significant others'. This reflexive processing allowed the co-construction between therapist and client of a 'macronarrative reformulation' of current and past experiences into a coherent framework of understanding. From this research, Hardtke and Angus (2004) became interested to see if these process observations were reflected in explicit changes in the stories that clients generated to describe themselves from before to after therapy. Preliminary results indicated that clients who were able to generate coherent narratives from their current lived experience to illustrate their shifting views of self were less likely to relapse at follow-up. This suggests that this method is able to identify differential outcomes in terms of clients gaining a greater or lesser degree of congruence between their current lived experience and their sense of self.

This method is unique in the field of counselling and psychotherapy outcome research in terms of offering a qualitative approach to a pre-post therapy design. Perhaps the closest alternative is the use of the personalised questionnaire approach covered in the quantitative self report section above. Similar to the PQRST and Simplified PQ, clients are asked to define their own criteria about what they are looking to change in therapy, providing an idiosyncratic view of outcome. Further, the initial interview questions may offer clients a focus and direction for their early therapy sessions. However, a significant conceptual departure occurs in the evaluation of change at the end of therapy. Where the personalised questionnaire approach relies on predetermined quantifications of change, the Narrative Assessment Interview allows the client to self evaluate the significance of changes based on their own perception of the difference in their self statements. This provides a truly client orientated approach to assessing the outcomes of therapy.

Overall, the Narrative Assessment Interview offers a novel approach to qualitative self report outcome data collection in terms of the ability to compare pre and post-therapy responses. Using this method, clients are given a unique opportunity in interview based outcome research to self evaluate change based on explicit pre-therapy statements rather than having to rely on retrospective recall alone. However, this key advantage also introduces a number of complexities. In the protocol as stated above, the client is reliant on the researcher's summary of the key points of the pre-therapy interview. This then becomes highly dependent on the researcher's ability to interpret the most salient responses, and to translate these into written words. Both of these are non-trivial processes, with the potential for significant 'data loss' in terms of content and verbal nuances. Further, this process is highly labour intensive and 'time critical' for the researcher, who must ensure the transcription and summary are completed before therapy finishes. Whilst this may be easily managed in a dedicated research project, it becomes more limiting in terms of utilising the approach more broadly. Hardtke and Angus (2004) indicate that a potential solution to this is to replay the original recording of the interview to the client rather than rely on the researcher's summary. However, this introduces its own disadvantages in terms of the time required to replay the recording, especially if the client wishes to stop and review sections. These limitations may explain the relative lack of uptake of the approach, as indicated by the absence of many further published studies using the method in the counselling and psychotherapy literature.

2.3.5 Solicited diaries, journals and other personal documents

As an alternative to interviews for collecting data, the use of diaries, journals and other personal documents (such as letters) has a long history in counselling and psychotherapy, reaching right back to Freud's interpretation of recorded dreams from the 1800s (e.g. Brill, 1911). Similarly, Allport (1942) highlights the origins of the use of personal documents in the psychological sciences stemming from the phenomenologist of the 1800s, along with mapping out the uses and forms of personal documents in the mid 1900s. More recently, Korotitsh and Nelson-Gray (1999) identify

how structured diaries, journals and logs have become a popular method for client self-monitoring within behavioural approaches to clinical psychology, both in practice and in research. With regard to contemporary psychotherapy research, Thiele, Laireiter, & Baumann (2002) identify two main methodological strategies employed by researchers adopting diary use to collect data. The first entails pre-structured instruments where respondents are typically asked to keep a quantitative record of specific subjective experiences, cognitions, behaviours or social interactions (e.g. amount of alcohol consumed, number of panic attacks, number of intrusive thoughts etc). The other approach yields more qualitative data in the form of narrative accounts of a participant's self disclosure with respect to some aspect of their lived experience. Either approach can be utilised to gather data at a specific interval (*interval contingent* - e.g. the end of the day), on a predetermined signal (*signal contingent* - e.g. a phone call from the researcher), or after a defined event (*event contingent* - e.g. after a panic attack) (Wheeler & Reis, 1991).

It would appear that the use of diaries and journals to gather quantitative outcome data on counselling and psychotherapy is relatively common. In a review of outcome studies published in the Journal of Consulting and Clinical Psychology between 1995 and 2000, Farnsworth et al (2001) identified diary use as the third most commonly used self report measure, appearing in 7% of the reviewed papers. However, surprisingly few researchers have employed diaries to gather more detailed qualitative data for their therapy research. In a review of qualitative diary studies in psychotherapy research, Mackrill (2008) was only able to identify four published accounts, all largely verbatim reports from clients which had not been formally analysed in any systematic way - e.g. Rogers' (1951a) account of Miss Cam's diary entries made after her therapy sessions. Mackrill contrasts these 'unsolicited' diary reports with 'solicited' diaries used in other forms of social science research. Here, participants are specifically requested to write about an area of interest relevant to the research being undertaken, rather than whatever spontaneously arises. This provides a focus for the diary content, allowing a systematic analysis similar to that undertaken with qualitative interviews discussed above. In his own study, Mackrill (2007) used solicited qualitative diaries to explore the connection between what goes on in therapy sessions, and client's experiences in their day to day life. This approach allowed Mackrill to investigate therapeutic change from the perspective of the client's ongoing lived experience rather than considering change to be limited to the 'therapeutic hour'. However, Mackrill's focus was more on the process of change rather than explicitly looking at the outcome of therapy. In particular, Mackrill was interested in how clients used therapy, rather than what they got out of it.

With regard to studying the outcomes of counselling and psychotherapy, it would appear that no studies have as yet systematically employed solicited qualitative diaries as the central data collection method to evaluate change. However, Burnett (1999; Burnett & Van Dorssen, 2000) has utilised personal documents in the form of a letter written to a friend to gather solicited qualitative data from counselling clients which was then systematically analysed to evaluate the outcomes of

therapy. This ‘letter to a friend’ (LTF) technique has previously been used in the assessment of learning in an educational context. As cited in Boulton-Lewis (1995), Tang and Biggs (1995) adapted a method proposed by Trigwell and Prosser (1990) to elicit a ‘portfolio’ of data including letters written early on and then again later in a unit of a course. Using the Structure of Observed Learning Outcome (SOLO) taxonomy (Biggs & Collis, 1982, 1989 as cited in Boulton-Lewis, 1995; TEDI, 2003), Tang and Biggs were able to systematically evaluate changes that had occurred in participants on the course. Burnett’s (1999) adaptation of this protocol was a tentative attempt to explore the utility of the ‘letter to a friend’ (LTF) technique in combination with the SOLO taxonomy to assess the structure of learning gained from counselling. The protocol requested clients to write a letter to a friend describing in as much detail as possible what they had learned and how they had gained or benefited from counselling. This innovative data collection method appears to have yielded in-depth responses from clients enabling a detailed qualitative analysis and evaluation of the outcomes of therapy.

From a methodological perspective, Allport (1942) contends that the use of personal documents in psychological research allows for a ‘touchstone’ on reality, a more ‘common sense’, naturalistic and idiographic approach to the goals of science which can balance the potential for psychology to focus on abstract findings derived from nomothetic methods. In particular, qualitative personal documents allow researchers to access a person’s subjective experience contextualised within their every day life, rather than being limited to data collected within a research or therapeutic setting. This sets them apart from qualitative interviews, which are typically conducted in the researcher’s territory (either physically or psychologically) and hence offers greater ‘ecological validity’ (Bronfenbrenner, 1977b, see Section 3.2.3). Similarly, personal documents allow researchers to ‘see into’ a person’s lived world as it is experienced, rather than as it is recalled in a research interview, and offers a solution to the problem of retrospective recall (Bolger, Davis, & Rafaeli, 2003). Further, when utilised in a longitudinal design (such as with diaries), personal documents offer a method for the researcher to gain a more ‘fine grained’ access to complex, self regulated processes, allowing them to watch the course of development and change over time (Schmitz & Wiese, 2006).

From the perspective of the individual participant, this type of data collection method would also seem to offer a number of benefits. Mackrill (2007) reported that clients used their diaries as a reflective medium to help make sense of aspects of their lives, and to reveal new aspects of themselves to themselves. This sometimes took the form of ‘reflection in action’, of participants reflecting in real time as they wrote their diary. This can be seen as clients extending their engagement with the therapeutic process out with the therapy room, and of taking greater ‘ownership’ of this process. Similarly, Burnett and Meacham (2002) highlight the many claims of the value of learning and reflective journals for participants, such as providing a tool for critical reflection, allowing a different perspective to be formed, and facilitating catharsis or self

expression. Mackrill (2008) also proposes that, compared to interview studies, clients have more control over what is revealed, and that they can choose more freely what to include and exclude without the social pressure of a researcher or interviewer being present.

Though solicited qualitative diaries, journals and other personal documents such as ‘letters to a friend’ would seem to offer an excellent approach to collecting rich and detailed data on the client’s lived experiences of their engagement with therapy, a number of authors have also highlighted limitations with these methods. Bolger, Davis, and Rafaeli (2003) note that the effective use of diaries in this manner potentially necessitates considerable training of participants on the research protocol to ensure clarity of what is to be recorded and when. Further, keeping regular and accurate diary entries places a high burden on the participant, requiring a commitment and dedication rarely required in other types of research. Mackrill (2008) highlights the potential for significant variations between participants in both quantity and quality of response, and the potential for a diarist to go ‘off track’. This is compared to interview studies where a researcher can ask additional prompt questions to elicit further detail, and can bring a focus to responses to keep the interview ‘on track’ from a research perspective. Further, both Mackrill (2008) and Burnett (1999) acknowledge that a certain level of language and writing ability is assumed, which may be problematic for some participants with literacy problems, physical impairment, or cultural difference.

Overall, solicited diaries, journals and other personal documents offer a largely untapped potential with regard to qualitative counselling and psychotherapy outcome research. From a research perspective, they offer a method of gaining access to a client’s every day life world, with a potential to increase the ecological validity of studies that conceptualise change in terms of a person’s lived experience. From the client’s perspective, it would seem that this approach offers the potential to extend their engagement with the therapeutic process, potentially enhancing therapy outcomes. The limitations of this method suggest that it would be most beneficial when used in conjunction with other methods of data collection, such as research interviews which could be used to focus the client’s responses and to elicit more in-depth exploration on specific areas of interest to the researcher.

2.3.6 Electronic data collection and Ecological Momentary Assessment

Advances in technology over the last decade or so offer researchers many new forms of data collection. For example, the diary method discussed above which has traditionally been implemented in a ‘paper and pencil’ form can now be implemented using portable electronic devices such as palmtop or wrist computers, and pocket PCs or PDAs (Personal Digital Assistants). Portable digital audio recorders make it possible for participants to audio record their journal entries on the go and speech recognition software even allows these to be automatically

transcribed. Webcams and video recorders incorporated into mobile phones and PDAs now make it easy for people to record their own video diaries. The expanding technology incorporated into mobile phones in particular makes these devices a potential gold mine for qualitative researchers. Not only can text messaging be used as a response mode, but also picture messaging and video messaging. Further, through mobile internet connections, participants could interact directly with online web based research applications, allowing a much greater degree of sophistication.

As with the structured diary method discussed above, cognitive behavioural therapy has been the predominant area in which electronic data collection has been used within the field of psychology. In particular, an approach called Ecological Momentary Assessment (EMA) has emerged as a popular method both in clinical practice and research. EMA entails the moment to moment collection of data from a participant in real world settings (Stone & Shiffman, 1994; Shiffman, Stone, & Hufford, 2008). For example, in a study by Muehlenkamp et al. (2008) of emotional states preceding and following acts of non-suicidal self-injury in bulimia nervosa patients, participants were asked to respond to pre-selected questions on semi random signals from a palmtop computer 6 times a day (signal-contingent), as well as after specific events (event-contingent) and at the end of the day (interval-contingent). Similarly Yoshiuchi, Yamamoto, and Akabayashi (2008) review the use of EMA for stress related diseases, including using watch-type computer devices where respondents used simple analogue scales to report intensity of symptoms, but which also automatically recorded physical activity through an inbuilt 'actigraph'. This highlights the potential of the computerised data collection method to record additional information along with the self report data, such as exact time of day, duration to complete the assessment, location (via GPS), psychical activity (via accelerometer), and other physiological data such as heart rate (Shiffman, 2007). The potential here is to develop 'context sensitive' EMA (CS-EMA) systems where the request for self report data is tailored by triggers from various sensors indicating a specific activity or location (Intille, 2007). In addition, a recent pilot study by Tsai et al. (2007) reveals the potential of mobile phone technology to act not just as an assessment, but also as an intervention. These researchers are designing a 'patient-centered assessment and counseling mobile energy balance' system which not only collects data, but has the potential to proactively present tailored information that may lead to health-related behaviour changes.

Though EMA is typically used to collect quantitative data, the method can also be adapted to collect more qualitative data. An example of this is a study by O'Connell et al. (1998) which augmented the quantitative electronic data collected on a hand held computer with an 'experience log' recorded on audio tape. The use of audio recordings in conjunction with EMA has been taken a stage further by Mehl, Pennebaker, Crow, Dabbs, and Price (2001) in their use of an electronically activated recorder (EAR) to record momentary 'sound bites' throughout the day. The recorder was programmed to automatically record 30 seconds of audio every 12 minutes to provide the researchers with a rich source of information about the settings of the participants as well as the

ways they interacted with others. Initially developed using analogue tape recorders, the system has evolved to use PDAs providing greater flexibility and storage capacity (Mehl & Holleran, 2007). The potential to extend this technology even further is demonstrated by a research project called 'MyLifeBits' currently being undertaken by a group of Microsoft computer engineers (Gemmell, Bell, Lueder, Drucker, & Wong, 2002). The project involves compiling a digital archive of the life of one of the researchers, Gordon Bell, including recording all his communication with others, as well as the images he sees via a portable digital video recorder, and the sounds he hears using a digital audio recorder (Bell & Gemmell, 2007). It has been commented that this life log, or 'flog' would make an interesting adjunct to therapy, by providing the ability to bring a person's lived life more fully into the therapy room and reviewing what has gone on since the previous session (Roy, 2006). Similarly, from a therapy research perspective, this technology offers the researcher an unprecedented level of immersion in a participant's lived world, providing a depth of unedited situational and social interaction data unheard of using currently employed techniques.

Though electronic data collection offers numerous benefits to the researcher, Shiffman (2008) summarises a number of limitations and ethical concerns with these methods. As with the diary methods discussed above, electronic data collection can require considerable training of participants, especially if they are not 'computer literate' or familiar with the hardware used. Further, the limitations of some devices such as small screens and keyboards may make them unusable for some populations such as the elderly. Perhaps the most problematic aspect is the potential for hardware malfunction and the resultant loss of data. Associated with this is the limitation of battery and data storage capacity which may mean a device 'runs out' in the middle of the day. Data management is also a concern as the method can provide a potentially excessive amount of data, especially if taken to the 'life log' level. This approach also highlights confidentiality and consent issues. While a participant may have given consent, there are significant ethical issues about using interactive data with others who have not given their explicit consent to participate. For example, with the electronically activated recorder used by Mehl, Pennebaker, Crow, Dabbs, and Price (2001), recordings of interactions with random 'others' in a participant's life could be quite revealing and personal to the other person, yet they may have no direct contact with the researchers, and hence no say in how the data is used.

From the participant's perspective, electronic data collection potentially offers significant benefits over paper based methods. Problems highlighted in the previous section about the literacy requirements of diaries are significantly reduced and almost eliminated through the use of audio and video recording. These methods also potentially reduce the time burden, especially if recordings are automated such as with the EAR system. The portability of modern devices allows data entry to be made anywhere, at any time. This is especially so if devices are used by participants as part of their every day life, as is the case with mobile phones and PDAs. Participants don't need to remember to take their diary or journal with them, it is effectively there. Further, the

use of these devices is much more discrete and ‘every day’ than with paper based methods. There is also potential for greater confidentiality using simple data encryption such that only the participant and researcher can access the information recorded. Finally, and perhaps most significantly, with CS-EMA there is potential for data collection to be highly tailored to an individual’s current activity or situation, such that a person is only asked to self report when appropriate, and that the questions asked are specifically tailored to the person’s immediate context.

In summary, electronic data collection and EMA offer intriguing new possibilities for qualitative researchers in the field of counselling and psychotherapy. Unprecedented levels of both quantitative and qualitative data can potentially be captured within the context of the client’s lived, every day life. Perhaps the most problematic aspect of this approach, however, is this very potential. Typically, qualitative data analysis is a painstaking process of data reduction, from many hours of interview recordings down to a few significant themes that illuminate the original research question. How much more daunting would be the task of sifting through many hundreds, if not thousands of hours of unfocused recording to find moments of potential significance to the research being undertaken. Here, new methods of data search and retrieval would be required to fully utilise the collected material. This is one of the aims of the Microsoft ‘MyLifeBits’ project discussed above, however this is far from being a consumer product available to the research community.

2.3.7 Client autobiographical and personal accounts of therapy

Though typically not intended as a direct source of qualitative data on the outcomes of counselling and psychotherapy, client autobiographical and personal accounts potentially offer a unique insight into what individuals have got out of their therapy. Books such as Alexander’s (1995) “*Folie a deux: An experience of one-to-one therapy*”, Sands’ (2000) “*Falling for therapy: Psychotherapy from a client's point of view*”, Bates’ (2005) “*Shouldn't I be feeling better by now?: Client views of therapy*”, and Davies’ (2006) “*My therapy*” along with journal articles such as Bassman (2000; 2001), Frese (2000), Lynch (2000), and Tenney (2000) would seem to offer a valuable insight into people’s helpful and hindering experiences of therapy (Glass & Arnkoff, 2000). The potential here is that research could be undertaken to utilise such accounts as qualitative data in order to hear what is being said about ‘outcomes’. For example, the account by Tenney (2000) states that what consumers want is “mental health services that focus on helping people identify what factors will promote their recovery” (p1440) rather than simple symptom reduction, and offer “freedom of choice, the sense of empowerment, and the problem-solving skills that gear people toward recovery” (p1441). Here, Tenney’s writing has a sense of authority, clarity and ‘empowered-ness’ which is quite different from that likely to be heard from a research interview or solicited personal document. This may well be the product of the process of writing for publication, which requires a different ‘ownership’ of what is communicated, and may provide insight into different dimensions of outcome than other qualitative methods discussed so far.

Similar to the adaptation of solicited methods to the digital age discussed above, unsolicited client accounts of therapy have also become available in electronic form. Recently, digitised client narratives have become available in an online searchable collection containing first-person accounts of their counselling and psychotherapy (Alexander Street, 2008). More significantly, the internet has provided clients with an unprecedented form of mutual exchange and peer support (Kennedy, 2008). Here there is potential to undertake a form of observant ethnography on a person's interactions with others in terms of their unsolicited postings on discussion forums, 'chat rooms', web logs (blogs), and social network sites such as Facebook, MySpace and Twitter. Using this method, researchers can easily gain access to a wealth of naturalistic data that may also span a significant duration of time (Murray & Sixsmith, 2002). This potential is partially demonstrated in a study by Høybye, Johansen, and Tjørnhøj-Thomsen (2004) of the effects of storytelling in an internet breast cancer support group. The design of this study included both the use of the unsolicited content of the support group discussion forum as well as solicited online 'chat room' interviews with a researcher to study personal accounts over time of the transformation of women's lives after the diagnosis of breast cancer. The results of the study indicate that participants tended to transform from feeling disempowered to feeling empowered, and suggests that it is possible to investigate changes and outcomes for participants using this approach. With regard to counselling and psychotherapy research, this method may provide a system for tapping into client's unsolicited reflections in their therapy process, as well as changes in the way they interact with others.

From the client perspective, the value of this form of qualitative data collection is the potential for it to be completely non-invasive. The client is largely writing for themselves rather than writing for a researcher, in so far as the researcher is just another reader of the material. This means the client is in complete control of how much they choose to reveal. Further, there is some evidence that people find it less threatening to reveal personal and sensitive material in writing compared to a face to face interview, especially online (Murray & Sixsmith, 2002). Additionally, as much of the material is likely to be available in the public domain (in the form of published books or online discussion forums), researchers do not need to overtly intrude on a person's life in order to access the data. As such, this form of data collection could be seen as the least problematic for clients, as they are not directly involved with the research.

However, concerns have been raised with this very issue of "public-ness" and the resultant uncertainty over the need to gain explicit consent. Eysenbach and Till (2001) summarise the ethical issues surrounding this with regard to online support groups. They point out that the definition of what is 'public' versus 'private' is often unclear and open to interpretation, and may vary from group to group. Even when a group is considered 'private', there are circumstances where informed consent can be considered to be waived. This creates the potential for online communities to be covertly observed, with researchers 'lurking' on discussion forums. This can be experienced as

intrusive and damaging to an online community, with group participants feeling taken advantage of, and even abused by the researcher (King, 1996). A further issue with the use of unsolicited online client material in qualitative studies relates to the anonymity of the author. Due to the nature of the internet, search engines make locating strings of text exceedingly simple. This creates significant issues when incorporating verbatim quotations in the write up of a study, as is standard practice in qualitative research. Any reader can simply search for the quote and locate the source of the post, thus revealing the online identity of the author (Sixsmith & Murray, 2001). A further issue raised by Sixsmith and Murray (2001) regards the ownership and authorship of material taken from the public domain and incorporated into qualitative research. From a legal perspective, it can be argued that including any form of direct quote from such material without explicitly crediting the source is a breach of copyright. However, explicitly identifying the source would inherently breach confidentiality. This would seem to require gaining explicit consent and copyright waiver from all the authors of the material used, which then negates the non-intrusiveness of this method. These issues are not easily resolved, and present an ongoing challenge to the use of such material for qualitative enquiry (Kennedy, 2008).

A method of using personal, autobiographical accounts in qualitative research that avoids the tension between the interests of the author and that of the researcher is the use of auto-ethnography. Auto-ethnography can be seen as a blend of ethnography and autobiography (Scott-Hoy, 2002) offering the potential for clients as researchers to 'tell their own story' within the context of formal research. It entails the researcher performing some form of narrative analysis on their own lived experience in order to explicate a phenomenon of interest (McIlveen, 2008). The aim is to extend and enhance both the researcher's and the readers' understanding of the issue being investigated (Sparkes, 2000). An example of this approach in the field of counselling is a study by Etherington (2005) into the experiences of people who have suffered childhood trauma. Etherington gathered 10 participants' stories (including her own) showing how they had made sense of childhood trauma and the ways they had found to heal. This study demonstrates the potential to hear detailed, reflective accounts of client's situated experiences of healing, which could be used to help inform us of beneficial and problematic outcomes of therapeutic interventions, as well as contextualising these within a wider set of resources.

From the client as researcher perspective, this approach means that the author is much more aware of, and in control of the potential implications of their involvement. Further, the client's voice is not subsumed by the researcher's, as they are one and the same. Within the mental health profession, the method can also be seen as professionally beneficial with regard to furthering self awareness as a reflective practitioner, in terms of greater self knowledge and understanding of one's own thoughts, feelings and experiences (Foster, McAllister, & O'Brien, 2006). However, the nature of the method means that any possibility of anonymity is lost, making it highly revealing of the 'self' of the researcher, both personally and professionally (Flemons & Green, 2002). This is

particularly problematic in the field of counselling and psychotherapy where the subject matter is often deeply emotive and personal. Here the researcher risks exposing themselves to unknown future repercussions or even discrimination. There is also potential for the research to be perceived as self-indulgent, a form of personal navel gazing which does not contribute in any meaningful way to broader knowledge (Sparkes, 2002).

The above approaches to collecting qualitative data from autobiographical and personal accounts of therapy potentially offer researchers a very different view of the outcomes of counselling and psychotherapy than would otherwise be possible. Published books and journal articles typically present a more reflective, 'processed' view of peoples experiences, while online material typically captures a sense of less edited peer communication. However, use of such material outside the context from which it was intended needs to be undertaken tentatively and with awareness of ethical considerations. Autoethnographic studies would seem to offer a method where the research context can be interwoven with the client's personal account. The use of this method offers the potential to access client's in-depth and situated reflections on the outcomes of therapy. However, the method is also highly revealing of the 'person' of the researcher, making it extremely personally and professionally challenging.

2.4 Part 3: Beyond numbers and words – Visual self report methods

Visual self report methods can be seen as offering an alternative form of data collection which is not reliant on either words or numbers. Sperry (1973) argues that science, and indeed modern society in general, has tended to favour the cognitive and expressive functioning associated with the left hemisphere of the brain such as the analytical thinking and reasoning required for linguistic and numeric processing. In contrast, processes associated with the non-verbal right hemisphere of the brain such as creativity, insight, holistic perception, spatial construction, pattern matching, etc have been discriminated against. Deacon (2000) contends that this traditional privileging of numbers and words over more creative forms of data has inherently limited our ability to study living, dynamic systems. Similarly, Harper (2002) suggests that visual methods “evoke deeper elements of human consciousness than do words; exchanges based on words alone utilize less of the brain’s capacity than do exchanges in which the brain is processing images as well as words” (p.13). From this perspective, Oster & Gould Crone (2004) propose that visual methods offer a form of communication with a richness, uniqueness, complexity and spontaneity that can go beyond ordinary awareness and is not usually available through words alone. Following is an overview of a number of visual methods which offer the potential to be utilised for investigating the outcomes of counselling and psychotherapy from this more non-verbal perspective.

2.4.1 Using photos and video as self report data

The previous section on Electronic data collection and Ecological Momentary Assessment (see Section 2.3.6) touched briefly on the potential for modern technology to facilitate the use of visual methods in research such as photos and video. This visual approach to qualitative data collection has gained increasing acceptance and usage within a number of diverse fields, including anthropology, sociology, health and nursing studies, educational research, criminology, social and cultural geography, media and cultural studies, discursive and social psychology, management and organisation studies, political science and policy analysis (Knoblauch, Baer, Laurier, Petschke, & Schnettler, 2008). In particular, participatory approaches to visual data collection offer the potential to more fully ‘hear’ a participant’s ‘voice’ (Thomson, 2008). Studies have been conducted with participants taking photos (Kaplan, 2008) and compiling video footage (Haw, 2008) from their own perspective in order to give researchers a different picture, literally through a different lens. These approaches have afforded researchers new insight into what is considered significant ‘space’ and ‘place’ from the participant’s perspective which may have gone unnoticed using other methods.

From a participant's perspective, a key advantage of self reporting via photo or video compared to using written or spoken reports is the lack of linguistic or narrative skill required (Kaplan, 2008). The image can 'speak for itself' without the need for a lengthy and detailed description. Further, the method can be engaging and 'fun' when compared to compiling a lengthy written response such as a diary or journal entry. Additionally, the process of actively compiling such visual data can facilitate a different 'ownership' and 'authorship' of the research, whereby participants become more the 'director' rather than the 'subject' (Thomson, 2008). Here the researcher takes on the role of 'viewer' whilst the participants are the 'creators' of the data, potentially adding a dimension of engagement and empowerment to the research. In terms of their use in outcome research, photos and video provide a convenient way to capture events in a person's life. Especially using modern digital equipment, a large volume of data can be collected and stored, then reflected on at a later date. Images used in this way may help stimulate a participant's recall of events in a far richer, more detailed fashion than from memory alone.

Though photos and video would seem to offer many benefits as self report methods of data collection, a number of key issues have been identified with the use of visual research in the social sciences. Grady (2008) contends that while such images may appear to provide a more direct and immediate record of the actual events being investigated, there are significant issues with how this data is interpreted. Without the 'analytic frame' of a research interview, images in isolation lack a narrative coherency and may be interpreted in dramatically different ways. Similarly, Thomson (2008) points out that images are never a simple window into a person's world, but rather are a construction that has the potential to deceive and manipulate, either intentionally or unintentionally. Further, the potentially evocative nature of images may lead to them having an impact quite different and unforeseen than originally intended. Likewise, while a benefit of the 'image' is that it focuses attention on a specific aspect in a moment in time, this can create a disproportionate emphasis which can be taken out of context when seen by others (Kaplan, 2007). These issues can lead to a 'distorting' of the captured data in unintentional and unpredictable ways.

With regard to counselling and psychotherapy outcome research, a further problem arises in terms of the ability to access the 'inner world' of participants. While photos and video are convenient for recording the world around us, they are not able to capture the thoughts, feelings and emotions that accompany the recorded 'scene'. Even when the use of images is combined with qualitative interviews, our tendency to see photographs and video as being 'real' and 'factual' may still cause problems. Without a stoically critical self scrutiny, the too literal interpretation of images may well close down a dialogue of possibilities, multiple views and differences in meaning (Kaplan, 2008). These issues may explain the lack of uptake of this approach in counselling and psychotherapy outcome research. At this time, no studies have been found that attempt to use these visual self report methods of data collection.

2.4.2 Projective techniques

A visual method which attempts to gain access the ‘hidden’ inner world of participants beneath the overt interpretation of the image is that of projective techniques. Semeonoff (1976) describes this approach as “a method of enquiry based on self-revelation through the handling of a perceptual or other structured stimulus or situation” (p.vi). The basic premise of projective techniques is that everyone to some degree ‘projects’ their own traits, attributes or subjective processes on to what they perceive (English & English, 1958, as cited in Semeonoff, 1976). Projective techniques attempt to make use of this by typically providing a relatively unstructured or ambiguous stimuli or task and then observing how an individual perceives, interprets or structures the situation (Anastasi, 1988). A classic example of this approach is the Rorschach Inkblot test. Here an ordered sequence of ten ‘inkblots’ are presented to a person who is asked to relate what they ‘see’ in the picture. Responses are then scored according to various classifications, for example the location within the inkblot (e.g. whole, detail or white space), the content perceived within the inkblot (e.g. human, animal, nature) and other features attributed to the inkblot such as colour, shading, texture etc (Weiner, 1999). This information is typically collated into numerous ratios, percentages and indices which can be used to generate inferences about personality functioning similar to personality assessment questionnaires such as the MMPI-2 discussed previously (see Section 2.1.1).

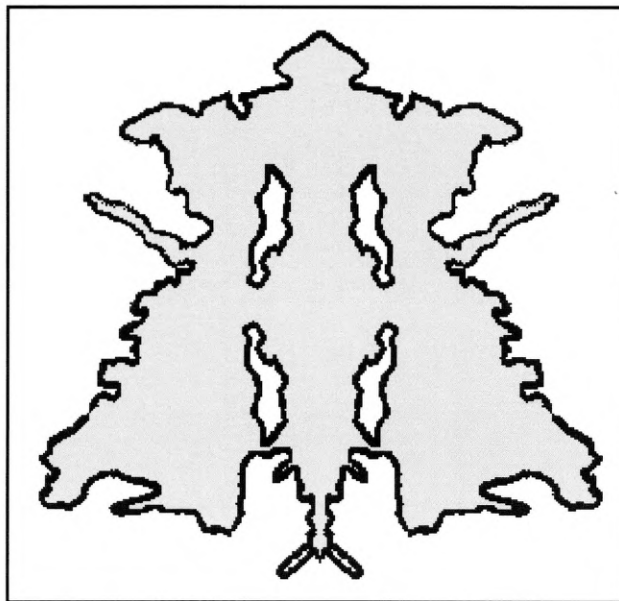


Figure 2-3 Outline of an inkblot similar to the Rorschach (TheInkBlot.com, 2006)

In addition to eliciting verbal responses to preformed images such as with the Rorschach, projective techniques have also been used in a more generative or expressive style where a participant is asked to draw something. An example of this approach is Buck’s (1949) House-Tree-Person technique which quite literally asks a person to draw a picture of a house, a tree and a person. The instructions are left purposefully vague so as to facilitate the ‘projection’ of the participant onto the task. Both the content and the approach to completing the drawings are then scored along a number of dimensions. Scores are calculated for the amount of *detail* (e.g. the lack

of a chimney in the diagram of the house below), the *proportional* characteristics of the image (e.g. the size of the tree in the diagram is too large for the page), and the *perspective* of the drawing (e.g. the image of the person is absolutely centred on the page). Both this quantitative data and more qualitative observations used to interpret the drawings. For example, an excessive detail score would suggest strong overt concerns with superficial aspects of everyday living, while an enlarged nose could be interpreted as a phallic substitute indicating sexual maladjustment (Buck, 1949).

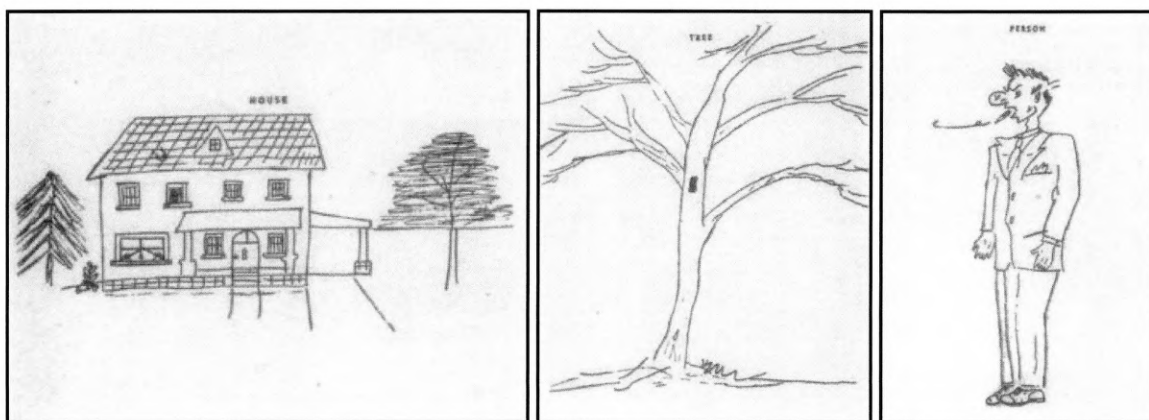


Figure 2-4 House-Tree-Person projective diagrams (Buck, 1949 p.38)

Interestingly, in terms of the discrimination of science towards cognitive/analytical methods as discussed above, projective techniques have tended to be highly criticised for their lack of scientific validity, however their use in clinical practice would appear undiminished (Lilienfeld, Wood, & Garb, 2000). Within a clinical setting, it would seem that projective techniques are valued by practitioners as a more subjective, idiosyncratic method of accessing a client's unique frame of reference rather than as nomothetic measures (Clark, 1995). The value of this more idiosyncratic approach can be seen in the above example where during the qualitative exploration of the diagrams, the clinician discovered significant 'hidden' details. For example, the trees around the house symbolised the person's father, brother and mother revealing further spatial and proportional qualities, while more poignantly the scars on the tree represented the death of a playmate at four, and the death of the brother at 15. These uniquely individual associations add a depth of meaning to the drawings which would not be possible through a purely objective, nomothetic analysis.

In terms of the value of this approach to qualitative research, Anastasi (1988) suggests that projective techniques may work best as a supplement to qualitative interviewing. Used in this way, they may act to 'break the ice' during the initial contact with a researcher by providing a more interesting and entertaining method for engaging participants compared to standardised questionnaires. Further, Begley and Lewis (1998) propose that this approach may be especially valuable in facilitating communication with 'verbally limited' groups due to the reduced language comprehension and production demands. Buck (1949) suggests similar benefits of his technique, adding that the act of drawing may be so emotion-producing that it promotes participants to verbalise previously suppressed material. Further, the drawings constitute a permanent sample of a

participant's behaviour which can be used for comparison in longitudinal studies. Seen from this perspective, projective techniques would appear to offer a valuable adjunct to qualitative research interviews, and could be utilised in a pre-post design offering a method for comparing the qualities of a client's responses from before to after therapy.

An interesting study which has utilised this approach to evaluate the outcomes of therapy is that conducted by Flitton and Buckroyd (2002). As part of an evaluation of a schools based brief (14 week) person centred counselling intervention, learning disabled children were individually interviewed before and after their therapy. Included in the interviews was a projective technique of asking participants to visualize an animal or object that they felt represented them, and then to make a visual image of this on paper using a selection of drawing material such as paint, crayons, pencils, pens etc. Interviews were recorded and a photograph of the image taken. Rather than quantitatively analysing the drawings, the participant's own descriptions of their images were used to construct rich individual narrative accounts of the changes in their self concept from before to after therapy. The write up of the results of the research included evocative individual accounts of the each child's images, and the meaning they placed on them. From these accounts, the researchers were able to draw conclusions about changes in the participants' self concept, and relate this to the relative success of therapy. This method allowed the researchers to enquire into the inner perceptual world of a potentially vulnerable group of participants with respect and sensitivity.

From a client's perspective, the use of projective techniques as a nomothetic measure is highly contentious (Lilienfeld et al., 2000). Numerous articles have been published warning people not to submit to projective tests when the results will be used in any official capacity. In this regard, the value of this approach as a self report measure is highly dubious as a person's responses are often 'interpreted' out of context. In particular, the use of elaborate quantitative scoring systems may give the illusion of 'objectivity' which is not supported by the research literature (Anastasi, 1988). However, when used more idiosyncratically and collaboratively, there would seem potential for projective techniques to provide an interesting method for clients to reflect on the changes they experience from therapy. The projective element of this method offers the potential for less conscious dynamics to be revealed to the participant themselves. When used in a respectful manner, this may be both empowering and insightful, offering the potential for insight from the research process itself (Fischer, 2000).

2.4.3 Art therapy assessment

Another therapeutic tradition which embraces visual methods as a central medium is that of art therapy, where clients are encouraged to explore their feelings using art materials such as paper and paint, collage, clay or sculpture (Hogan, 2001). Gilroy (2006) contends that the use of art in therapy

allows the movement between worlds, between inner and outer spaces, between the visual and the spoken word, and that it can access somatic, preverbal, presymbolic material and ‘subvert’ the conscious mind into revealing previously unconscious psychological relationships. Further, art can provide a physical, tangible form for the interior monologues of a client which is touchable, visible, and available for review and dialogue with both self and others. Similarly, in terms of art therapy assessment, Schaverien (1993) identifies that client artwork provides a concrete, lasting and specific means for evaluating and monitoring therapeutic interventions. Here the concept of a ‘retrospective exhibition’ from the field of art history can be drawn upon, where a chronological sequence of artwork allows links to be made between pictures, and a re-evaluation of the meanings of particular works in the context of those preceding and following it, allowing new understandings to emerge (Schaverien, 1993). Schaverien (1993, pp 94-97) cites numerous instances of this approach in the literature such as the ‘illustrated case studies’ published by Jung (1959), Milner, (1969), Winnicott (1971), and Edinger (1990) where the changes which are seen to take place in the pictures of clients are also seen to echo those that take place in the client’s inner world.

Schaverien (1993) goes on to highlight the value of artwork for the researcher or therapist in terms of the evocative nature of pictures allowing a more vivid recall of details than could be attained by other methods. Here affect from the past can be seen to be carried ‘live’ into the present, offering the potential for a much richer analysis of other collected data such as case notes, interview transcripts etc. Similarly, McNiff (1998) contends that art based research has the potential to tap into a rich history of alternative attempts to ‘know’, and to provide different types of knowledge than traditional research methods. Further, McNiff suggest that artistic expression is a vitally important way of acquiring and communicating information about human experiencing. Rather than being at odds with ‘scientific’ ways of knowing, McNiff indicates that both science and art can inform each other, offering an integrative form of enquiry which goes beyond either approach in isolation.

Art therapy assessment methods have traditionally been influenced by the earlier use of projective techniques (see Section 2.4.2) such as Buck’s (1949) House-Tree-Person drawings (see Figure 2-4) whereby a person is asked to create a series of pictures in response to a standardised drawing task. For example, one of the earliest forms of art therapy assessment, the Ulman Personality Assessment Procedure (UPAP. Ulman, 1965; Ulman & Levy, 2001), requested a person to complete a series of four chalk drawings, the first a free drawing to act as a baseline for interpretation, the second to draw movements, the third to draw rhythmic scribbles, and finally a choice of either free or scribble drawing. Drawings were then typically subjected to expert clinical judgement to establish whether they portrayed signs of diagnostically significant psychological disturbance. Significantly, with regards to the interpretation of images, Ulman and Levy (2001) recommend a shift away from attempting to discern the symbolic meaning of the content of

pictures as was standard practice with projective techniques, to instead focus on isolating formal elements of graphic productions and their relationship to personality.

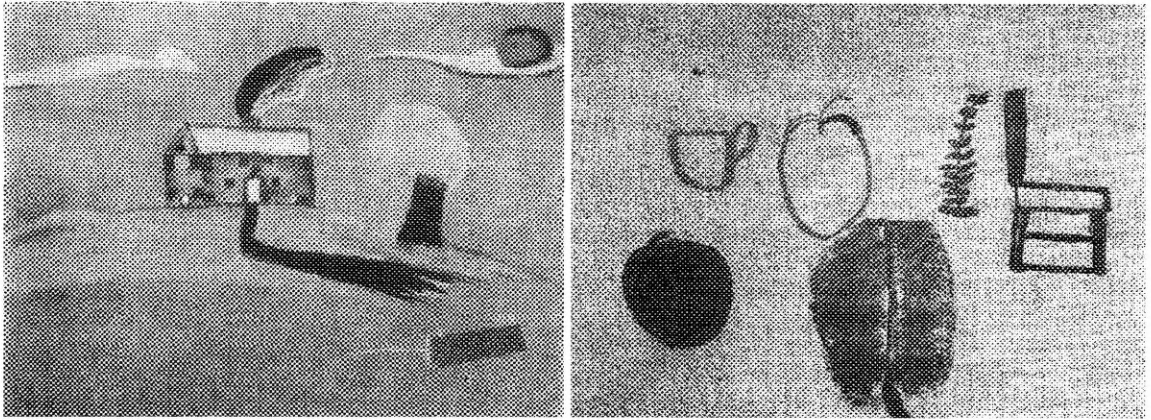


Figure 2-5 Ulman Personality Assessment Procedure drawings (Ulman & Levy, 2001)

Later researchers have attempted to formalise this shift towards more generalised concepts drawn from art literature for the interpretation of client artwork. Rose (2007) identifies this form of analysis as ‘compositional interpretation’, and refers to literature on the interpretation of paintings as a guide. For example, Acton (1997) identifies composition (including vertical and horizontal alignment, asymmetry, harmony and balance), space (between objects and in terms of perspective), form (especially human figures), tone (contrast between light and shade), and colour as the basic ingredients used to create an image. It is this approach that the Formal Elements Art Therapy Scale (FEATS) devised by Gantt and Tabone (Gantt, 1998; Gantt & Tabone, 2003) utilises to construct a rating scale that can be used to assess a person’s drawings. Specifically, drawings are rated on a 14 item questionnaire for prominence of colour, colour fit, implied energy, space, integration, logic, realism, problem solving, developmental level, details of objects and environment, line quality, person, rotation and perseveration. For example, prominence of colour is rated on a 5 point Likert scale from “Color used for outlining only” (0) to “Color used to fill all available space” (5), development level is rated from “Two-year-old level” (0) to “Adult level” (5), and line quality is rated from “Broken, damaged lines” (0) to “Fluid, flowing lines” (5).



Figure 2-6 Drawings of a person picking an apple from a tree (Gantt & Tabone, 2003)

The FEATS is most commonly associated with the “Draw a Person Picking an Apple from a Tree” (PPAT) task (Gantt & Tabone, 2003). Here a person is literally asked to draw a person picking an apple from a tree (see Figure 2-6). Drawings are then rated by the researcher or therapist using the FEATS system in conjunction with a detailed and illustrated rating manual. Additionally, a 13 item check sheet can be used to record the presence or absence of features including orientation of picture (horizontal/vertical), colours used (blue, red green, brown etc), environment details (e.g. sun, moon, grass, mountains etc) and other features such as the use of writing, numbers, geometric shapes and random marks. These ratings can then be compared to a database of results from different populations to establish a psychological diagnosis.

In contrast to requiring a specific drawing task, other art therapists promote a ‘free drawing’ or unstructured approach to the creation of pictures for assessment and evaluation. Here a person is given a free choice of what to draw and the materials to use (Rubin, 1973, 2005). Using this approach, assessment can involve noting the way a person engages with the drawing task, the materials used, as well as the end product itself (Rubin, 2005). Rather than evaluating a drawing using predefined criteria, Rubin (2005) suggests an interview process for understanding the artwork, starting with *looking intently* at what has been created in order to take it in, then using *open-ended questions* such as what it was like to complete the drawing, what a person was thinking about when drawing, what a person sees in their picture etc. This can be followed by *exploring and extending associations* by asking what comes to mind while looking at the drawing, whether it reminds a person of anything, what is ‘happening’ in the picture, or asking someone to make up a story about their artwork. Finally, Rubin recommends asking for a *client’s own assessment* of the quality of their artwork, including what they like or dislike about their picture, what they would like to have done differently etc. Rubin believes that this type of enquiry yields richer responses and is less threatening to clients than more regimented post drawing interrogations.

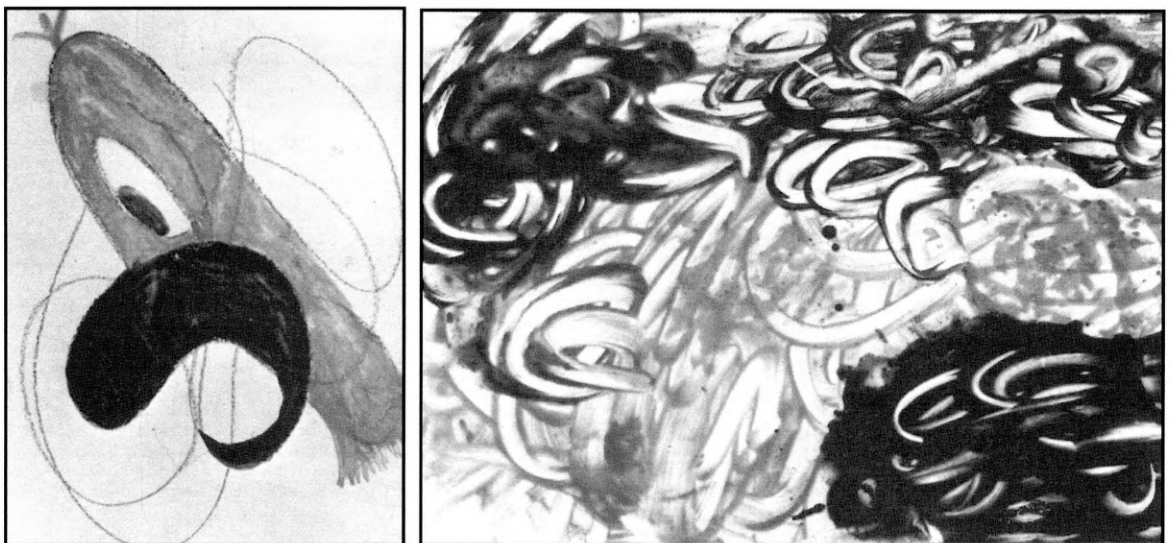


Figure 2-7 Free drawings (Rubin, 1973)

Though this free drawing approach offers a great deal of flexibility, Ruben (2005) notes that it can be difficult for clients to know where to begin when confronted with a blank page and no specific instructions. Her advice in this respect is to use ‘visual starters’ which provide a starting point upon which a person can elaborate. These may be a pre-existing dot, line or shape; the invitation to begin with something non-threatening such as a scribble or squiggle (Winnicott, 1992); or a stimulus drawing which gives a person an idea of what they could draw.

From the client’s perspective, a significant limitation of traditional approaches to art therapy research is the tendency for artworks to be interpreted in an essentialist, modernist manner (Gilroy, 2006). Images are seen to be ‘of’ the person, to reveal an essence of a person rather than being a co-construction of the client and therapist/researcher. Further, pictures are usually interpreted independently of their social, political and cultural context. Hence the meanings imbued in a client’s picture tend to be limited by the researcher’s narrow ontological framework, and potentially reflect their own projections more than accurately capture meaning from the client’s perspective. Similarly, Hogan (2001) warns of the dangers of using fixed, dogmatic theoretical frameworks or of interpreting artwork using static psychological schemas in a reductive manner as being potentially abusive and disempowering for clients. Likewise, Betts (2006) states that the use of art-based assessments can be overly depersonalizing when it fails to incorporate subjective elements such as the client’s own verbal account of their artwork. Here the ‘free drawing’ approach suggested by Rubin (1973; 2005) offers a much more collaborative method for assessment, though this can be difficult for clients to know where to begin.

Overall, art based research offers a promising but largely untapped approach to investigating the outcomes of counselling and psychotherapy. McNiff (1998) encourages researchers to go beyond the ‘artistic amplification’ of case studies, and to employ pluralistic designs which tap into the strengths of both ‘scientific’ and ‘artistic’ ways of knowing. He foresees the potential for art based research to utilise the rigour and systematic approach of empirical methods while still attending to the aesthetic qualities and introspective nature of artwork. Here McNiff (1998) suggests that identifying art-based approaches to outcome assessment which embrace these aesthetic qualities and allow a ‘creative enquiry’ are of greater importance to the field than attempts to justify or prove itself. Further, he encourages exploration of different approaches to evaluating and reporting of outcomes, such as the retrospective observation of the art making process by both client and therapist, or the use of artistic and dramatic methods for the presentation of results.

2.4.4 Timelines and lifelines

In contrast to projective drawings and art therapy approaches to research which generally attempt to reveal the *meaning* of pictures, drawing techniques can also be utilised in a more straightforward, direct manner as tools for research participants to relate information. For example,

methods such as timelines and lifelines offer a way for researchers to facilitate a structured recall of significant things as an adjunct to qualitative interviews. These methods are especially useful for gathering information of a longitudinal nature, such as a life history, rather than focusing on isolated or single events (Deacon, 2000). The method typically uses some form of line with linear markings to represent events of interest (Tracz & Gehart-Brooks, 1999). Depending on the participant's drawing style and the nature of the research task, lines can be straight (e.g. Brott, 2004), or more curved and 'windy' (e.g. Guenette & Marshall, 2009). Event markings may be simple cross marks with labels, or more diagrammatic and pictorial (Tracz & Gehart-Brooks, 1999). Guenette and Marshall (2009) propose that timelines are particularly useful when research involves participants recalling sensitive or emotionally charged material. Here the timeline can act as a 'representational anchor', allowing sensitive topics to first be tentatively 'marked' on the line before being discussed at greater depth. Further, by standing back from and reflecting on the timeline as a whole, this approach allows a different perspective to be brought to events.

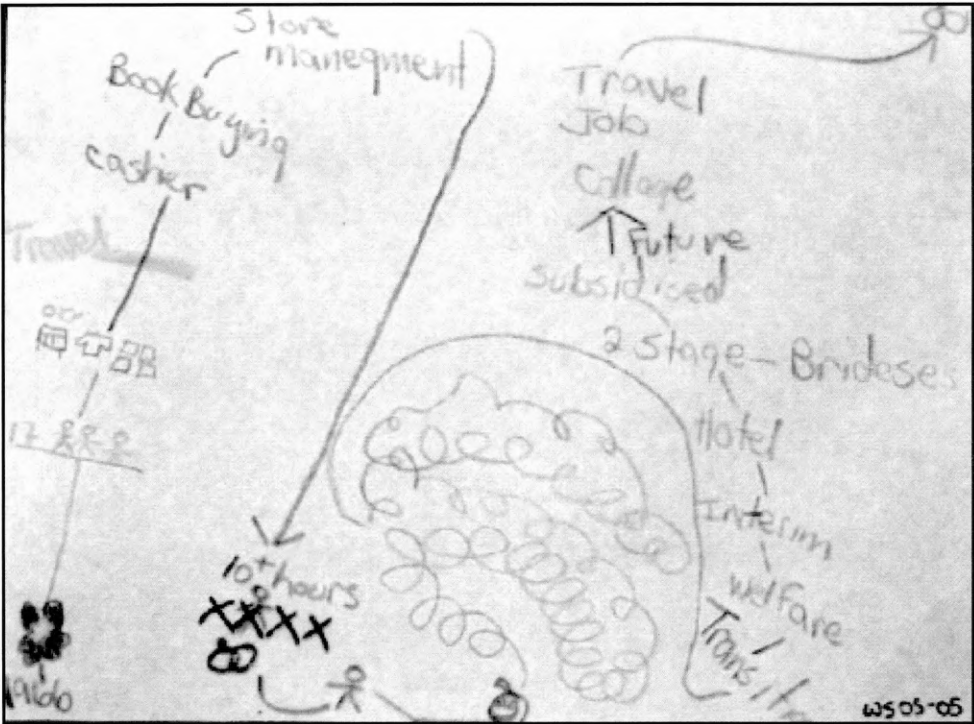


Figure 2-8 Timeline drawing (Guenette & Marshall, 2009 p.89)

Within the field of counselling and psychotherapy research, McKenna and Todd (1997) have used timelines to investigate how people made use therapy at different times in their life. Participants were asked to construct a timeline of their contact with various mental health services. Following this, semi-structured interviews were used for a detailed discussion of each event. Transcripts of these interviews were then analysed in order to extract the dominant themes within and across individuals. In terms of the use of the timeline method, the researchers were able to elicit rich individual accounts which they could then use in the write up of results to provide detailed narratives to exemplify the various types of 'episodes' of therapy. These included *exposure* to the

possibility of help before ‘shopping around’ or *discriminating* for a suitable service. Later, participants related *formation* episodes were significant and lasting change took place followed by *consolidation* and *holding* episodes.

With regard to the participants’ perspective of using the timeline method, McKenna and Todd noted that a number of people spontaneously commented on the extensiveness of their treatment histories. The authors suggest that the method offers a potentially constructive effect in terms of encouraging individuals to look at their treatment history as a whole rather than as a fragmented collection of therapies. This is similar to Guenette and Marshall (2009) who noted that their participants entered into a reflective space as they told their stories which seemed to allow them to engage at a depth that may not have happened without the use of the timeline. Further, Guenette and Marshall (2009) indicate that participants found the method facilitative in terms of expressing difficult and sensitive topics at depth, providing a form of expression which did not require explicitly ‘telling’ another person about their experiences. It would seem that time lines and life lines offer participants a valuable ‘tool’ to facilitate their recall of historical events, allowing a much richer, in depth exploration than would be possible using an interview alone.

2.4.5 Mapping techniques

Similar to timelines and lifelines, mapping techniques provide a method of representation that can be used to help participants to structurally organise and recall information. Whereas timelines provide a method for representing longitudinal data, maps are “graphic representations that facilitate a spatial understanding of things, concepts, conditions, processes, or events in the human world” (Harley & Woodward, 1987 p.xvi). Various mapping techniques have been used in the fields of social work, family therapy and others where the importance is recognised of seeing the individual as part of a wider ‘system’. These techniques include ecomaps (Hartman, 1995), social network maps (Tracy & Whittaker, 1990), node link maps (Dees, Dansereau, & Simpson, 1994), and various other structured and unstructured approaches such as flow charts, floor plans and free form diagrams.

One example of a highly structured mapping technique is the ecomap. This technique is intended to map the ecological system of a family or household, including the major systems within a family’s life space and the relationships between them. The intent here is to portray an overview of the family’s situation, including nurturant or conflict-laden connections between the family and the world (Hartman, 1995). Though ecomaps can be drawn from scratch they are often preformatted with major systems already included along with several empty circles which can be completed by participants (see Figure 2-9 below). Links are then drawn with different line styles representing different qualities of relationships, along with the direction of flow of energy or resources between the various systems.

Name _____
 Date _____

ECO-MAP

SOCIAL
WELFARE

WORK

HEALTH
CARE

EXTENDED
FAMILY

CHURCH

RECREATION

SCHOOL

FRIENDS

FAMILY OR
HOUSHOLD

Fill in connections where they exist. Indicate the nature of connections with a descriptive word or different kinds of lines: — for strong, - - - - for tenuous, + + + + for stressful.
 Draw arrows along the lines to signify flow of energy, resources etc: →→→
 Identify significant people and fill in empty circles as needed.

Figure 2-9 Pre-structured ecomap (adapted from Gingerich, 2009)

A similar structured approach to mapping that has been developed in the addictions counselling field is the node-link map technique. Rather than map a participant’s ecosystem, these maps are intended to visually represent the interrelationships among the thoughts, actions, and feelings that compose a person’s problems. The ‘nodes’ of a map are used to represent thoughts, actions, or feelings while the labelled ‘links’ are used to express their interrelationships (e.g. L = ‘leads to’, I = ‘influences’, P = ‘part of’). A key aspect of this approach to mapping is that rather than being a static representation, the map can effectively ‘grow’ as therapy progresses. Figure 2-10 below, for example, shows that the conceptualisation of *family relationships* is developed more fully at a later stage than the original map, while still later the affective elements of *hurt, pain and uncomfortable feelings* are added to the map.

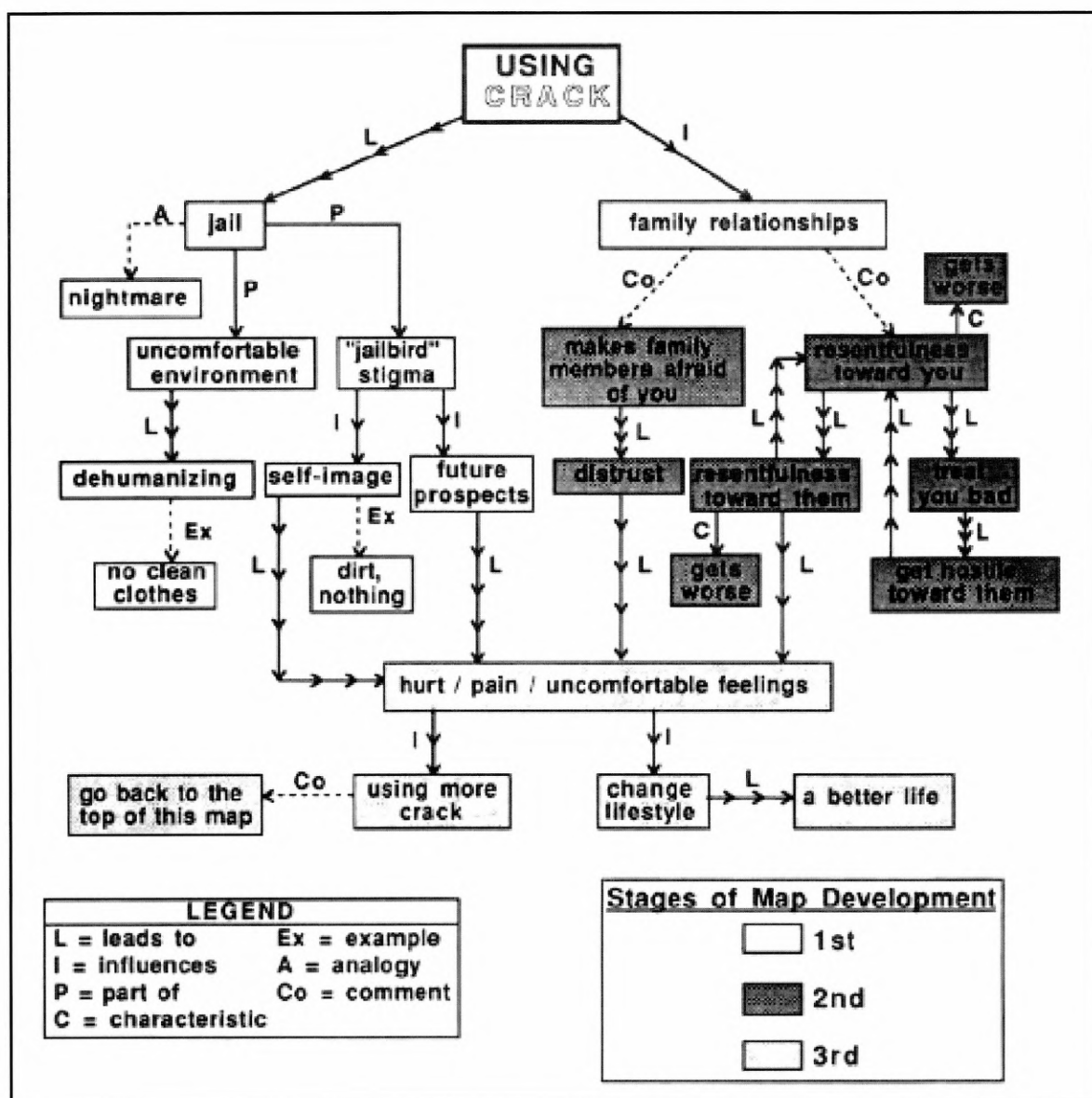


Figure 2-10 Node-link mapping (Dansereau, Dees, & Simpson, 1994 p.520)

Compared to the above structured approaches, ‘free mapping’ allows participants to diagrammatically represent their map in whatever format they wish. An example of this more free form approach called ‘life-space mapping’ has been used in the field of sociodynamic counselling (Peavy, 1997). This approach starts with a blank sheet of paper onto which a person represents themselves and their personal world including their present situation (see Figure 2-11 below). A person is encouraged to use lines, images, colours, words, sentences and symbols to construct a visual representation of their feelings, thoughts, actions and situational details that have meaning in relation to their current concern (Peavy, 2004). Using this approach, a person is free to map whatever is important to them, and to place different factors in association with each other using whatever representation fits best for them (see Section 3.6.4 for a more detailed discussion of Peavy’s approach to Life Space Mapping).

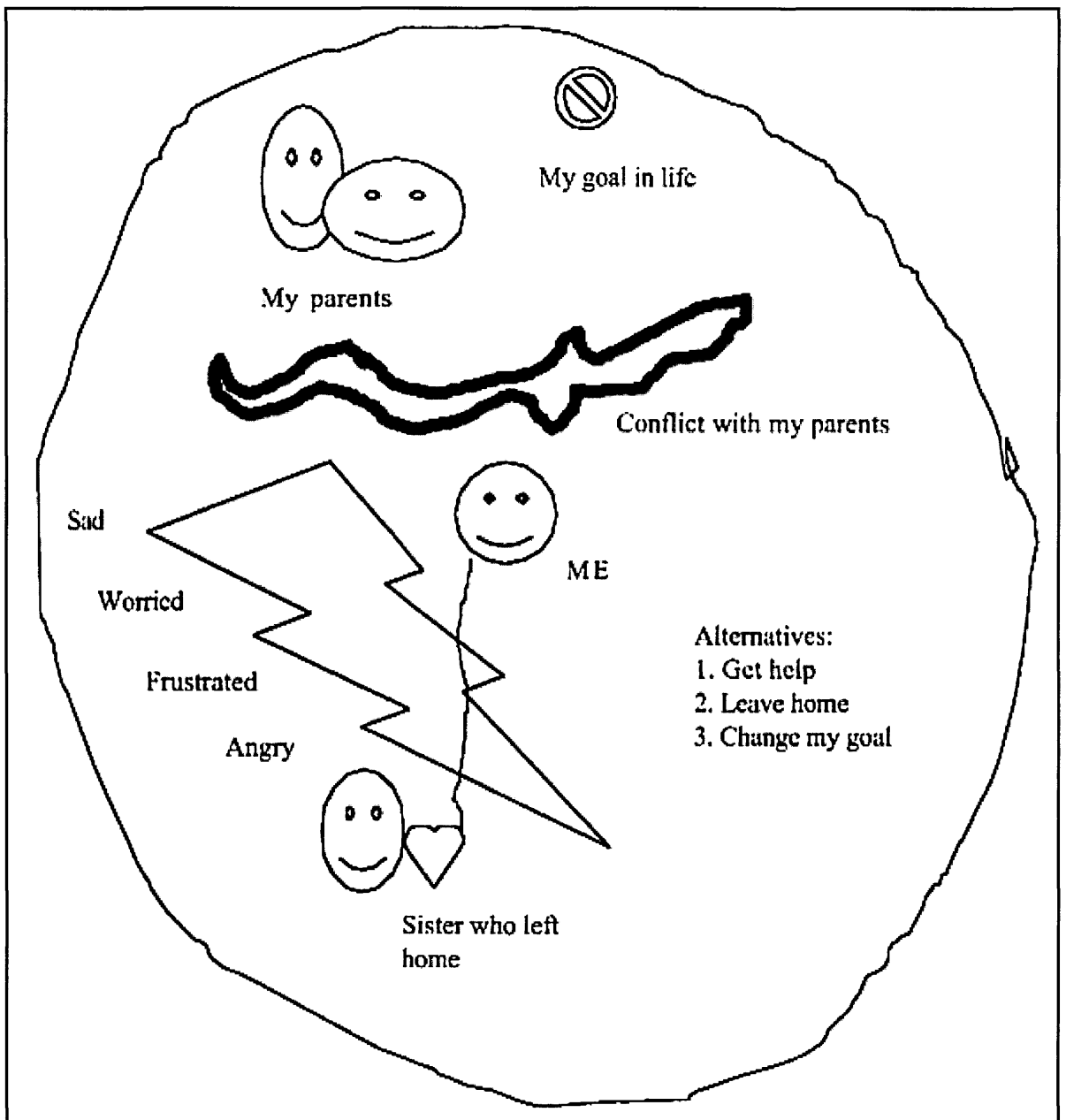


Figure 2-11 Life-space map (Peavy, 2004 p.83)

Whilst the above mapping techniques have principally been used in clinical practice, there is potential to adapt the approaches for use as methods of collecting qualitative self report outcome data. For example, the developmental approach to the node-link mapping by Dees and Dansereau (1993; 1994) could easily be used in a post-therapy qualitative interview to explicate change from the initial map. Further, a post-therapy map could be constructed with the researcher with which to compare the initial map. This potential is hinted at by Dansereau and Simpson (2009) when they say that maps “can be given to the clients as reminders or as vehicles for homework between sessions. They may also be reintroduced by the counsellor to evaluate changes and progress” (p.108). Similarly, Peavy (1997) includes a case example illustrated by the changes in a client’s maps over the duration of therapy. Interestingly, however, no published research articles were found that explicitly utilised a pre-post design using the mapping techniques described above.

From the participant's perspective, mapping approaches can be seen to have a number of potential benefits. Similar to Guenette and Marshall's (2009) discussion of timelines, Dansereau and Simpson (2009) suggest the mapping process may allow some participants express themselves more freely by not having to speak directly about their issues. Problems and issues can be put down on paper in a way which is potentially less threatening than having to say them out loud. Maps can also provide a concrete visual representation of issues which are not 'cluttered' by the extraneous words and comments of conversation. In this way, they can act as a 'distillation' of an interaction, helping to clarify and simplify complex situations (Peavy, 2004). This may help a participant to gain an overall perspective on their situation, as well as revealing previously unforeseen influences and patterns. Further, from the perspective of investigating the outcomes of counselling and psychotherapy, this concrete, distilled representation may act as a poignant and vivid 'anchor' for post-therapy recollection of how things were before therapy began.

2.4.6 Benefits and limitations of visual self report methods

From the above review, it can be seen that visual methods offer a number of benefits for therapy research. These methods provide a non-verbal approach which may allow less conscious, or at least less 'left brain' responses to be revealed both to the researcher and the participants. This approach would also seem particularly beneficial when research involves highly sensitive topics or potentially vulnerable participants. For example, in research with children Leitch (2008) proposes that visual methods "have potential for helping them narrate aspects of their consciously lived experience as well as uncovering the unrecognised, unacknowledged or 'unsayable' stories they hold" (p.37). Similarly, when doing researching involving asking women about their past experience of abuse, Guenette and Marshall (2009) found that the visual approach used in the study helped participants to move beyond a scripted retelling of their story, shifting them out of the words of a story they had spoken many times to a deeper sense of their experience. Further, the structure of methods such as timelines and mappings may help to contain and organise a person's recall of events bringing a greater focus and depth of engagement. This is born out in the studies reviewed where researchers were able to engage participants at a depth and encourage rich narrative accounts to be told. It would seem from this that the approach fits best with a narrative, idiosyncratic approach to data collection and analysis which allows the detail and depth of participant's stories to be heard. This can then be augmented with the actual pictures providing a further 'dimension' to a study.

With regards to outcomes research in the field of counselling and psychotherapy, visual methods may be especially beneficial in cases where changes are more 'right brain' than 'left brain'. In instances where holistic change, or changes in the structure or 'shape' of a problem or situation have occurred, diagrammatic and drawing approaches may 'speak the language' of this more non-verbal part of the brain. This may be particularly relevant in terms of the 'gamma change' or 'quantum

shift' discussed by Golembiewski, Billingsley and Yeager (1976) above (see Section 2.2.6), whereby a participant's 'psychological space' has effectively become reorganised and restructured. Here visual methods offer a mechanism for capturing and representing these more abstract changes which are not so easily communicated using quantitative measures or even with qualitative interviews in isolation.

From the participant's perspective, visual methods can be seen as offering a further 'tool' to help a person articulate their experience. Rather than relying on methods which require either written or verbal responses, visual methods offer a mechanism whereby less coherent, less 'processed' or potentially less 'conscious' aspects can be expressed. Here there is potential to 'show' the researcher things that numbers or words alone could not express. Similarly, experiences that are too raw or too sensitive to 'tell' directly may be able to be expressed more abstractly in pictures or diagrams, allowing participants a 'safer' form of expression. There is also potential here of offering participants a more direct way of communicating with the reader of the research. Unlike typical quantitative or qualitative data which must be analysed and summarised by the researcher before being published, visual methods offer a medium for the participant's self expression to be included verbatim, without any 'processing' by the researcher. By including this 'unprocessed' data in the write up, clients can effectively 'speak for themselves'.

These benefits of visual methods, however, also pose a number of potential problems. As highlighted by Grady (2008), Thomson (2008) and Kaplan (2007) above in the discussion of photos and videos, visual data is never a simple window into another person's world. The intent and perspective of the person constructing an image may be very different to that of the viewer. Each viewer will have their own 'lens' through which they see and interpret the image, which may be very different from the original author's. This is particularly so given the difference in what Banks (2001) terms the 'external narrative' of an image, the "social context that produced the image, and the social relations within which the image is embedded at any moment of viewing" (p.11). Visual data generated by a participant in a research project in response to specific requests from a researcher may well be 'viewed' very differently by a practitioner reading a published journal article. This creates significant potential for misinterpretation and indeed a misrepresentation of the participant when such data is presented without being 'framed' or contextualised appropriately.

Further, while visual methods may be beneficial in capturing more 'right brain' or non verbal changes, they may be overly cumbersome and even hindering in terms of measuring more linear changes such as Golembiewski, Billingsley and Yeager's (1976) alpha and beta change discussed above. Here, quantitative methods may allow a much more succinct and direct evaluation of change. Further, if a participant is more familiar and comfortable with working in a cognitive, verbal 'left brain' way, the request to be more creative may be quite daunting or be experienced as

too revealing, or seen as just plain 'odd' (Deacon & Piercy, 2001). Oster and Gould (2004) even suggest that participants may feel 'regressed' by using 'early' drawing methods such as finger paints etc, and care must be taken to avoid actual harm from the use of such methods. In relation to this Deacon and Piercy (2001) highlight the need to consider the participant's "formal and creative thinking abilities, groundedness in reality, physical limitations, sensitivity, openness, and need for crisis intervention" and warn that "None of these activities should be used if they put clients at risk of harm (emotional, physical, ethical, or otherwise)" (p.369).

2.5 Conclusions from the literature review

As Lambert (2004) states in his introduction to "Begin and Garfield's Handbook of Psychotherapy and Behaviour Change":

Change in humans is so complex that it is difficult to study the full meaning of the modifications that take place in treatment. Symptomatic changes often have a meaning component that is seldom studied in traditional research. The errors and oversimplification that inevitably arise in psychotherapy research often come from the complexity of a research task that is simply too daunting, rather than from carelessness, ignorance, or naivety. Few studies even attempt to examine the full range of consequences of entering treatment at a propitious moment in the life of a client who is enmeshed in a family and social context. (p12)

This statement eloquently highlights the enormity of the challenge faced by researchers. Hundreds of books have been written from dozens of therapeutic traditions theorising on different changes processes, let alone the innumerable self help books, spiritual tomes, philosophical texts and other works that propose varying understandings of what it means to be a well functioning human being. Further, clients are never in isolation but rather are in a unique family and social context, itself embedded within a distinctive culture, all of which are forever changing over time. Given this, it is easy to see how research has tended to simplify the concept of 'outcome' to something relatively manageable, and to ignore the seemingly impossible task of capturing the individual nuances of 'outcome' for different clients.

However, it can be argued that the actual measures used in research have a significant impact on how we 'see' change. For instance, from a natural science perspective, to measure change in a body of liquid it would be possible using a ruler to measure changes in depth, while with a thermometer it would be possible to measure changes in temperature, and yet again with a hydrometer it would be possible to measure changes in density. All these instruments provide valid measures of change, but all measure very different characteristics of change. As such, it can be seen that the qualities of

the tool used to measure change can inherently define what is considered 'valid' change. Traditional approaches to change measurement have focused on psychometrically sound and statistically proven 'batteries' of tests within a quantitative, 'natural science' framework. This approach has given the field a semblance of credibility in terms of being able to claim a sound 'evidence base', and the establishment of validated 'empirically supported treatments'. However, this approach to change measurement is impractical for practitioners wishing to demonstrate the efficacy of their day to day practice. Here the need for briefer, more practical approaches to outcome measurement has resulted in more 'clinimetric' measures such as the CORE-OM and OQ-45 being developed, along with the later introduction of abbreviated measures such as the CORE-10 and OQ-10. Further, idiosyncratic measures such as the Simplified Personal Questionnaire allow both researchers and practitioners to evaluate change on an individual level by tracking problems or goals that are specific to each client.

Each of these approaches to quantitative measurement can be seen as an attempt to look at change from different perspectives. However, it has been argued that these methods inherently impose a view of change which is essentially linear in nature. Clients are rated before their therapy on whichever measure is used, then again at the end of therapy, and the difference is taken as a representation of change. Qualitative researchers argue that such an approach is inadequate for investigating a complex, multi dimensional intervention such as counselling and psychotherapy. As an alternative, a number of approaches to qualitative data collection have been used to explore the outcomes of therapy. These have offered fresh insights in participants' experiences of therapy, and what has 'come out' of it. Like the qualitative critique of quantitative research, however, visual researchers argue that the use of words alone does not adequately access the fullness of the client's experience as it only accesses the more linguistically structured and 'processed' reflections of change. The more non-verbal or right hemisphere of the brain is not as engaged in typical qualitative interview methods, meaning that this form of data collection again imposes a limit on what changes are 'seen'.

Despite the apparent potential of visual methods for bringing a new 'lens' to the field of counselling and psychotherapy outcome research, very few studies have been undertaken using this approach. In particular, no studies have been found that explicitly set out to investigate the participant's experience of using such methods, so little is known about the practical utility of this approach, or the different view of change that visual methods facilitate when investigating the outcomes of therapy. Though the reviewed studies which have utilised a visual approach often include ad hoc references to individual participant's experiences, the studies have not been explicitly designed to ask participants about what they found beneficial or problematic with the employed method. As such there is a need for a more detailed study of the client's experience of using visual methods for investigating the outcomes of counselling and psychotherapy from their own frame of reference.

3 THEORY

In addition to drawing on existing literature on visual research methods covered in the previous section, this study has also been influenced by a number of key theoretical concepts. In particular, Kurt Lewin's conceptualisation of field theory and the 'life space' forms the core foundation upon which the study is based. Other contemporary theorists who have drawn on Lewin's concepts have also been influential, particularly Urie Bronfenbrenner and Jurg Willi. Carl Roger's formulation of client centred therapy and the significance of the client's 'phenomenal field' has been a further key influence on the study. Similar to Lewin, a number of contemporary theorists have drawn on Roger's ideas, and some of these have also shaped the present study. In particular, David Rennie, Art Bohart, Karen Tallman, Mark Hubble, Barry Duncan, and Scott Miller within the field of counselling and psychotherapy advocate an agentic view of the client, while others such as Constance Fischer propose an individualised collaborative approach to assessment and evaluation. Many of these ideas and concepts have been brought together by Vance Peavy and his conceptualisation of SocioDynamic counselling as a creative co-constructive process. In particular, his using Life Space Maps in a counselling and training setting has been a direct source of influence in terms of their use in the present study as a research tool. Following is a critical review of the central points of these key influences. This is by no means an exhaustive coverage of each author's work or ideas. Rather, it is limited to those concepts that have informed and illuminated the current study.

3.1 Lewin's field theory and the life space

In a series of papers and books in the 1930s and 1940s, Kurt Lewin presented 'field theory' as a systematic approach to analysing causal relations and building scientific constructs within psychology (Lewin, 1935, 1936, 1938, 1939, 1943, 1952). At the heart of this conceptualisation was an attempt to present a single unifying theory which could be used by all fields of psychology (Lewin, 1936). In undertaking this task, Lewin identified a need to move beyond the general psychological principles which predominated at that time in America towards a more discriminating 'science'. Here he likened this task to the shift from an Aristotelian view to a Galileian view of the world, from identifying and categorising a thing according to its historical properties or regularity of behaviour, to investigating the underlying 'dynamics' of a phenomenon (Lewin, 1935).

3.1.1 *The significance of the individual case*

Lewin considered that the concept formation of American psychology was dominated by the question of regularity in the sense of frequency, that only the 'generalisable' was important and individual behaviour or events lost significance - "So long as one regards as important and conceptually intelligible only such properties of an object as are common to a whole group of objects, the individual differences of degree remain without scientific relevance, for in the abstractly defined classes these differences more or less disappear" (Lewin, 1935 p. 11). The challenge Lewin saw for psychologists was to find ways of conceptualising that allowed the investigation of the significance of individual differences, such that the *actuality* of human behaviour and development could be investigated, rather than a statistical 'average'. He likened the traditional approach to defining the 'law of movement on an inclined plane' by testing a large number of cases of stones rolling down a hill and taking the average, rather than trying to discern the actual 'physics' of the phenomenon (Lewin, 1935).

In contrast, Lewin felt that a careful consideration of each and every case was required, regardless of regularity or exceptional circumstances. Only by paying attention to the specific 'dynamics' of a phenomenon could it be fully understood. Rather than these dynamics being 'of' an object in isolation, it would be essential to consider the *interaction* of various objects. Hence the tendency for a stone to roll down a hill is not considered a property of the stone in isolation, but rather an interaction of the gravitational forces between the stone and the surface it is on.

3.1.2 *The person-environment field*

To encapsulate his thinking in terms of human behaviour, Lewin (1936) used the formula $B=f(P,E)$ – Behaviour (B) = a function (f) of the Person (P) and the Environment (E). This formulation indicates that a person's behaviour can only be explained by considering a combination of both the person and the environment. Here the environment (E) is not the physical environment but the *psychological* environment – the environment as it is *perceived* by the person. Further, the person and the environment are *interdependent* – the environment is considered a function of the person ($E=f(P)$) and the person is considered a function of the environment ($P=f(E)$). This creates a complex, dynamic field of interaction, and it is only by taking this into account that behaviour can truly be understood - "behavior has to be derived from a totality of coexisting facts, and these coexisting facts have the character of a 'dynamic field' in so far as the state of any part of this field depends on every other part of the field." (Lewin, 1952 p. 25). For Lewin, the study of the individual must also take account of their perception of the wider physical, social, political and economic world within which that person dwells.

3.1.3 *The life space*

Lewin (1936) used the term 'life space' to denote the totality of all the influences on a person at a given moment in time, both the outer environment and inner personal environment. Lewin believed that within this life space, 'psychical forces' were at work similar to the forces of physics. Each 'psychical object' within a person's life space existed not in isolation, but in constant relation to others, with areas of tension, and boundary zones between them. Rather than static 'personality traits' or 'pathological abnormalities', a person's psychological world was considered to be a natural, dynamic process of interacting forces, with a multitude of systems and sub systems throughout the life space. All actions and behaviours were seen as a result of an ever changing resolution of a multitude of 'psychical tensions' such that the whole maintains an equilibrium. This may entail various subsystems seemingly moving in 'the wrong direction', or an apparent increase in tension within a specific area. These processes should not be considered in isolation, however, but must be seen in the context of the whole life space, including the person's wider physical/social world.

3.1.3.1 Subjective nature of the life space

In defining the life space, Lewin adopted the axiom "What is real is what has effects" (Lewin, 1936. p19). For Lewin, this meant focusing attention on the subjective importance of aspects of the life space rather than attempting to objectively define all possible influences. To highlight the difference, Lewin used the terms 'quasi-physical' and 'quasi-social' to distinguish that which is 'real' for an individual from that which is 'objectively' real (Lewin, 1936). Two people can experience the exact same environment quite differently, and it is only by considering each person's unique, subjective experiencing of a situation that we can understand behaviour. Similarly, the same person can experience the same environment differently at different times. This is not to imply that the physical or social 'reality' are unimportant, but rather the intent is to bring attention to the meeting of the person and the environment. Physical and social 'reality' are seen to have an important 'shaping' quality, but what is of real interest is the way in which a person perceives their environment.

3.1.3.2 Ahistorical nature of the life space

Another important quality of the life space is the temporal view taken when considering influences on a person's behaviour. Rather than seeing behaviour as a product of past experiences or future expectations, Lewin believed that it is the person's current moment to moment experiencing of the life space which is important. In this way, similar to the 'quasi-physical', it is not the 'objective' history or future which is important, but rather the person's present subjective perception of that history or future - "According to field theory, behavior depends neither on the past nor on the future but on the present field." (Lewin, 1952 p.27). This view is a direct consequence of the principle that only what exists 'now' can have effects. Lewin (1936) states that "Since neither the past nor the future exists at the present moment it cannot have effects at the present" (p 35) and

“Past events can only have a position in the historical causal chains whose inter-weavings create the present situation” (p 35). As such, the life space is considered to have components which include the ‘psychological past’ and ‘psychological future’ which do influence the present field, but historical events are not considered to directly ‘cause’ present behaviour.

3.1.3.3 Spatial qualities of the life space

Lewin (1936) considered the spatial qualities of the life space not just as abstract metaphors, but as significant, differentiated dimensions of a person’s psychological world. ‘Psychic forces’ were seen to be vectors with a specific direction and magnitude. Psychological objects and regions within a life space were considered to have specific spatial relationships to each other, including levels of connectedness or separation, belongingness, as well as distance. Boundaries between regions possessed varying degrees of solidity, resistance or permeability. These concepts were used not only to describe a person’s external environment, but also the intrapersonal life space. Different ‘parts’ of a person were considered to have varying levels of connectedness/separateness, as being more ‘central’ or ‘peripheral’, and to have more/less permeable boundaries. The overall state of a person’s life space could also be described in spatial terms such as the level of stability, fluidity, or fracturedness. Lewin (1936) turned to topological mathematics in an attempt to find a formal language to describe these qualities in more detail. He used this approach to formally define such characteristics as the openness or closedness of regions, simple versus multiply connected regions, the sharpness and level of resistance of boundaries between regions etc. This language allowed Lewin to conceptualise and represent the life space in a specific and detailed manner, and to apply his theories in definitive, practical terms.

3.1.4 Representing the life space diagrammatically

One of the benefits of adopting a detailed spatial model of a person’s psychological world is the ability to represent these concepts diagrammatically. Lewin often used life space diagrams to communicate his ideas, such as Figure 3-1 below which shows a typical representation of person ‘P’ and their psychological environment ‘E’.

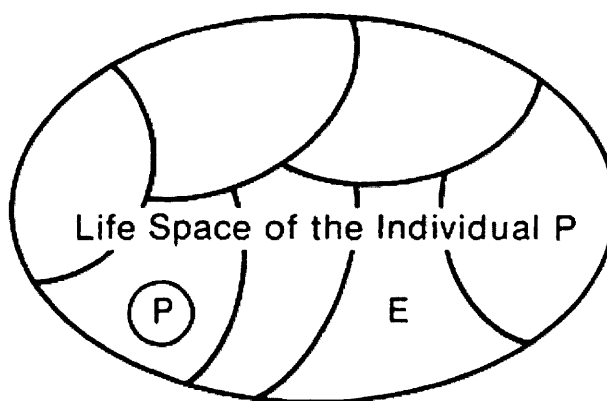


Figure 3-1 Representation of the life space (adapted from Lewin, 1936 p.73)

Similarly, the person's inner personal life space can be represented such as in Figure 3-2 which shows the different regions and parts of self with the external environment surrounding this. Here 'E' represents the external environment, 'M' the motor perceptual region, 'I' the inner personal region containing peripheral parts 'p' and central parts 'c'

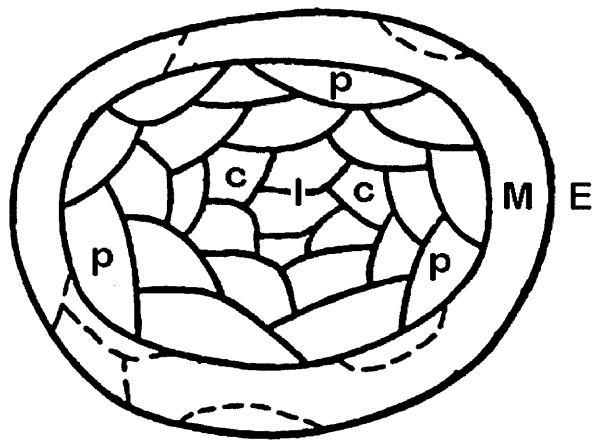


Figure 3-2 The inner personal life space (adapted from Lewin, 1936 p.177)

These diagrams illustrate how Lewin often chose a subset of the life space to consider. Rather than attempt to identify all possible influences and objects within a person's life space, Lewin would select a portion of the field which was relevant to the particular issue or topic under investigation.

3.1.5 Developmental changes in the life space

In his paper titled "Field Theory and Learning", Lewin (1952) identified four dimensions of possible developmental changes within the life space. These constitute *differentiation*, *restructurization*, changes in *time perspective*, and changes in the degree of *reality/irreality*.

3.1.5.1 Differentiation of the life space

Differentiation describes the tendency for unstructured areas of the life space to become more 'differentiated' – to be subdivided into smaller, more 'well known' units. To exemplify this process, Lewin used the example of a stranger arriving in an unknown city. At first the person knows only his arrival point, and the name of a destination. The 'city' has the quality of an undifferentiated space. Through enquiry, the person finds 'a way' from his arrival point to his destination. Over time, with repeated exploration and experience, the person becomes familiar with the city, and comes to know many different routes between many different points in the city. In this way, what was once an unknown 'city' becomes more finely differentiated into various sub regions, all interconnected and possessing differing qualities. The table below summarises some of the qualities of this differentiation dimension of developmental change over time.

From	Via	To
Unstructured Unknown Unfamiliar Unclear Vague Does not know No sense of direction Does not know what action will lead to what result	First steps Acquires an impression Come to know “a path which can be taken” An area “close to home” becomes known Learn “functional” relations between areas Large areas still unstructured	Know several paths Know different routes depending on situation Know from any one point to any other Know which paths are easy, and which are difficult

Table 3-1 Differentiation of the life space over time

3.1.5.2 Restructuring of the life space

In comparison to differentiation, Lewin (1952) used the term *restructurization* to describe changes in the live space which did not entail either an increase or decrease in the number of differentiated areas, but rather a change in structure. Here, Lewin used the example of the “detour problem” to demonstrate his idea. A young child standing within a U shaped barrier can not directly reach a desired goal on the other side of the barrier. However, after an ‘insight’, the child realises that they can reach the goal by first moving away from it, and going around the barrier. There is no change in the number of differentiated areas, but rather a change in the relationship between the areas, such that they are seen as interrelated and interlinked in a different way. The table below summarises some of the qualities of this restructurization dimension of developmental change over time.

From	Via	To
Blinkered Linear Goal ‘gripped’ Static / rigid Unable to see an alternative Unable to let go Disjoint Disconnected Disassociated Disorganised	See an intermediate point as a path towards final goal Can ‘let go’ in order to approach from different direction Link areas that were previously not connected New connections made	Non linear Dynamic / fluid See more complex paths Changed ‘meaning’ of direction Interconnected Integrated Part of a larger whole Have an overall view of a broader area Organised

Table 3-2 Restructurization of the life space over time

3.1.5.3 Change in time perspective and reality/irreality level of the life space

In addition to these structural changes, Lewin (1952) further defined changes in *time perspective*, and changes in the level of psychological *reality and irreality*. Time perspective refers to the totality of an individual’s view of their psychological past and psychological future at a given time. According to Lewin, during development a person’s time perspective expands such that more and more distant future and past events are incorporated into their life space. In addition, development

brings with it an increased differentiation in the reality-irreality dimension of the life space. As a person develops, they are better able to distinguish between wishes and facts, hopes from expectations. The tables below summarise some of the qualities of these dimensions of developmental change over time.

From	Via	To
Narrow view of time Only consider immediate past and immediate future Limited expectations	More distant future and past events considered Growing expectations of future	Enlarged view of time Broader view Future aspirations See further ahead

Table 3-3 Changes in time perspective of the life space over time

From	Via	To
Difference between reality and irreality blurred Does not clearly distinguish wishes/fears from facts, hopes from expectations Excessively high or excessively low aspiration Unrealistic evaluation of success or failure	Increased differentiation of reality-irreality More realistic goals / aspirations More realistic fears	Can distinguish between daydream wishes and reality, fantasy from fact Realistic aspiration - only slightly above past achievement Fears put into perspective

Table 3-4 Changes in the reality/irreality level of the life space over time

3.1.6 The concept of life space and the outcomes of therapy

Lewin’s (1936) conceptualisation of field theory and the ‘life space’ calls for a way of looking at the outcomes of therapy which take account of the detailed interaction between the person and their environment on a case by case basis. Rather than looking at an ‘average’ change in a predefined construct such as a person’s depression, anxiety or other problems across time, Lewin’s theories call attention to the need to investigate the details of an individual case more thoroughly. For example, instead of assuming items on a questionnaire can be combined, individual changes would be considered significant in their own right. Further, this view of outcome does not so much look at changes in a ‘property’ of a person (e.g. depression, anxiety etc), but rather change in the ‘dynamics’ of a person. This is a subtle but significant shift. Instead of measuring changes in the quantities of some conceptualised ‘property’ of a person (e.g. Problems, Functioning, Wellbeing, and Risk with the CORE-OM, or Depression with the BDI), Lewin’s theories refocus change in terms of how things are spatially related to each other within a person’s conceptualisation of their life world. Hence rather than looking at changes in the level of depression, or even changes in the qualities of their depression, a life space approach offers a method for considering changes in a person’s ‘relationship’ with their ‘depression’, or more accurately, the pattern and quality of interrelationship of the ‘things’ a person associates with their depression.

From this perspective, the four characteristics of Lewin's (1952) developmental model (*differentiation, restructurization, changes in time perspective, and changes in the degree of reality/irreality*) may provide an alternative way of conceptualising and perhaps even evaluating the outcomes of psychotherapy. For example, a person's view of their life might change from *"everything is dark and hopeless"* to a more differentiated view of *"when I am isolated and alone, I feel dark and hopeless"*. Even though the level of feelings may be similar, the conceptualisation of 'dark and hopeless' is no longer a blanket totality. In terms of restructurization, a person may further change to consider that rather than a causal link of *"when I am isolated and alone, I feel dark and hopeless"*, this becomes more *"my 'dark and hopeless' feelings are linked with my feelings of being 'isolated and alone' which I can now see are associated with my memories of being abandoned as a child"*. Here 'insight' can be seen to have 'shifted' the person's representational structure of the issue they are dealing with. Alternatively, a change in time perspective may occur, in terms of seeing that *"things feel dark and hopeless just now, but I know this will not always be the case as I have got through it before"*. Similarly, a change in reality/irreality may occur such that *"I know these feelings of being dark and hopeless are a product of my negative thinking, and cloud my view of life"*. These different changes may all produce similar 'quantities' of change on a quantitative measure of depression such as the BDI, but entail very different types of change which a linear conceptualisation can not capture.

A further implication of Lewin's (1936) theories is the need to consider the interaction between the person and their environment. Again this is a subtle but significant shift. Rather than problems being 'of' a person, issues can be seen to arise 'between' the person and their environment. Lewin stresses that this is not the 'objective' environment, but the person's psychological view of that environment, such that the environment and person are inherently interdependent. With regard to looking at the outcomes of counselling and psychotherapy, this requires a subtle shift in focus such that the person is no longer seen as primarily responsible or the root cause of their problems and issues. Rather, problems and issues arise between the person and their environment. In terms of standardised questionnaires such as the CORE-OM or the BDI, as indeed with most other outcome questionnaires, almost all items start with "I" or "My" such as *"I have felt tense, anxious or nervous"*. This subtly reinforces that the "I" of the client is responsible for problems and issues. Taking into account Lewin's perspective would require rephrasing items such that the "I" is no longer seen as primary. For example, the above statement could become *"There has been tension, anxiety or nervousness between myself and significant things in my life"*. This not only places the responsibility 'between' the person and the environment, it brings a primary focus to the dynamic of interest, in this case the *"tension, anxiety or nervousness"*.

3.2 Bronfenbrenner's ecology of human development

Throughout the 1970s, 1980s and 1990s Uri Bronfenbrenner published a number of papers and chapters which drew on many of Lewin's ideas to propose a new approach to conceptualising and researching human development (Bronfenbrenner, 1977a, 1977b, 1979, 1988, 1992, 2005). Bronfenbrenner considered his work an ongoing, evolving theory for the scientific study of human development over time (Bronfenbrenner, 2005):

Within the bioecological theory, human development is defined as the *phenomenon of continuity and change in the biopsychological characteristics of human beings, both as individuals and as groups. The phenomenon extends over the life course across successive generations and through historical time, both past and present.* (p.3, italics in original)

Though Bronfenbrenner's ideas and concepts originated from his work in child development, they have become influential in many other fields such as history, social policy, medicine, economics, political science, education and law (Lerner, 2005), as well as counselling and psychotherapy (e.g. Sugarman, 2004). Following are some key concepts that have shaped the present study.

3.2.1 The ecological environment

Bronfenbrenner viewed the environment not simply as the immediate surroundings of an individual, but interpreted Lewin's (1936) concept of the life space to include both the direct and indirect influences on a person:

the ecological environment is conceived as extending far beyond the developing person - the objects to which he responds or the people with whom he interacts with on a face-to-face basis. Regarded as of equal importance are connections between other persons present in the setting, the nature of these links, and their direct influences on the developing person through their effect on those who deal with him first hand (Bronfenbrenner, 1979 p.7).

Here the ecological environment is conceptualised as a set of nested 'systems of influence' - the 'micro', the 'meso', the 'exo' and the 'macro' (Bronfenbrenner, 1977b). The micro-system comprises the immediate settings of the person - the activities, roles, and interpersonal relations experienced in a given setting with particular physical and material characteristics. The meso-system comprises the interrelations among two or more settings in which the person actively participates (e.g. the relationship between a person's family, work and social life). The exo-system

refers to one or more settings that do not involve the person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the person (e.g. the neighbourhood, mass media, local and national government). Finally, the macro-system refers to cultural or subcultural patterns or consistencies in the form and content of lower-order systems which provide a ‘blueprint’ within a given society. (e.g. laws, regulations, the economy, ideology, customs, values, religion).

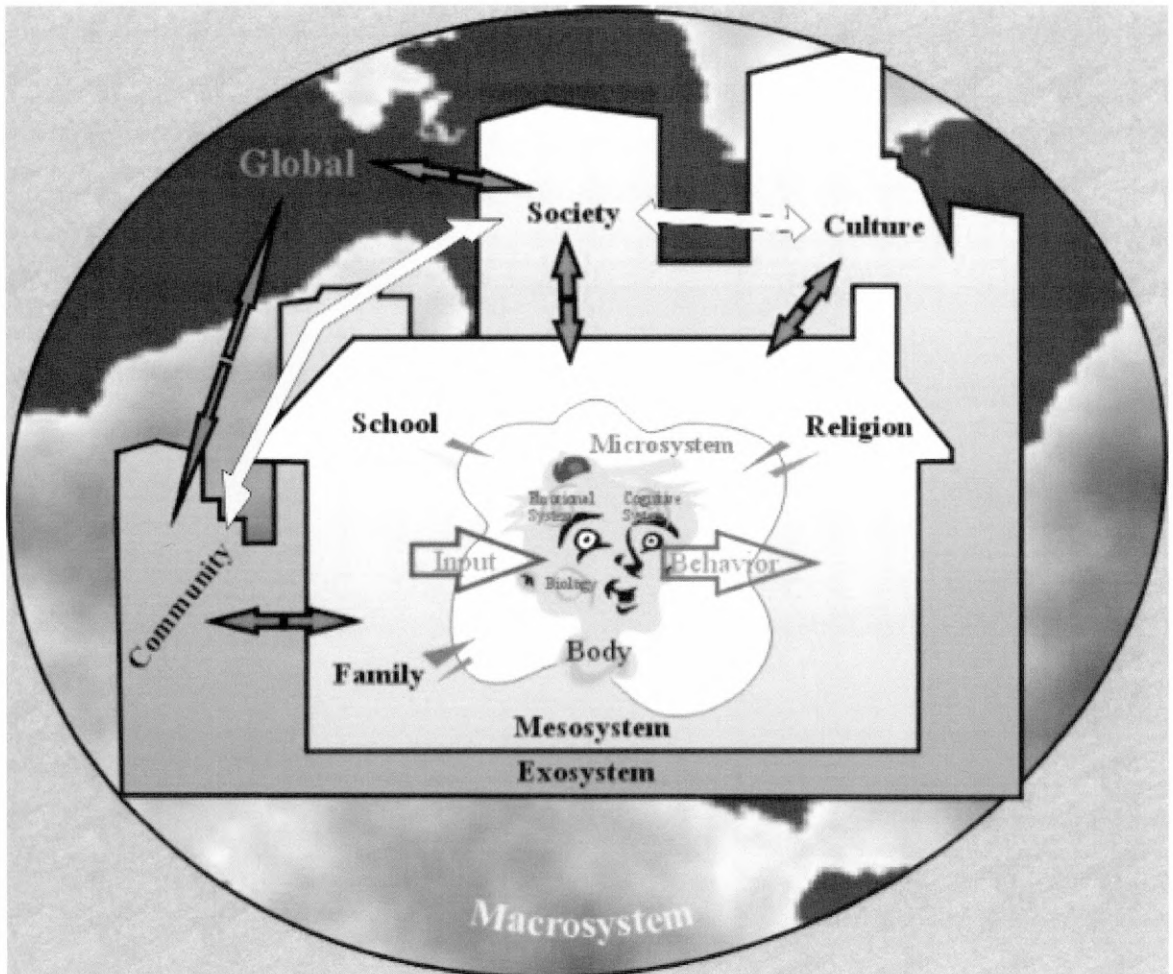


Figure 3-3 Bronfenbrenner's ecological systems theory (Paquette & Ryan, 2001)

3.2.2 Developmental change from an ecological perspective

With respect to conceptualising developmental change, Bronfenbrenner (1979) proposed that we should focus on psychological *content* rather than *process* – i.e. *what* is perceived, desired, feared, thought about etc and how the nature of this changes as a function of a person's exposure to and interaction with the environment. Instead of defining change in terms of traditional psychological processes (e.g. motivation and learning), development can be defined in terms of “the person's evolving conception of the ecological environment, and his relation to it, as well as the person's growing capacity to discover, sustain, or alter its properties” (Bronfenbrenner, 1979 p.9). Similar to Lewin, Bronfenbrenner conceptualised that rather than psychological change being purely a

function of the individual's psychological processes, it is the interaction with the environment which is seen as the significant change factor.

From a therapeutic perspective, this can be interpreted as rather than change occurring within an individual, or even between a therapist and an individual, it is the person's interaction with the whole 'therapeutic system' which engenders change. This radically challenges the individual centric approach to development and change which still predominates in the psychological sciences to instead embrace a much wider conceptualisation of the function and influence of the environment. Further, it challenges us to position the research of development and change within a larger, interdependent system rather than discrete, isolated entities. Bronfenbrenner (1979) states that "A theoretical conception of the environment extending beyond the behavior of individuals to encompass functional systems both within and between settings, systems that can also be modified and expanded, contrasts sharply with prevailing research methods" (p7) and "The detection of such wide-ranging developmental influences becomes possible only if one employs a theoretical model that permits them to be observed" (p4).

3.2.3 An ecological perspective on study of therapeutic outcomes

For counselling and psychotherapy research, Bronfenbrenner's (1979) stance requires a conceptualisation of change and development that incorporates a much wider field of interacting systems of influence than the traditional focus on the therapeutic relationship. These systems include the counsellor-client dyad, but then extend in all directions to include the client's interaction with their environment, the counsellor's environment and even the interaction of the clinical setting within its 'environment'. The real challenge here is to conceptualise and research *therapy outcome* in these terms, seeing that client change is inherently linked with a complex, interactive field of influence. In this sense, the environment is not a 'static variable' that can be controlled for and removed from the 'equation' of client change. Rather, the environment is part of the whole 'therapeutic system' in which a change in any one part will inevitably impact on other parts. As it is the whole 'therapeutic system' which provides the potential for change, not just the therapist, it becomes important to find ways of incorporating the larger therapeutic environment into outcome research.

Further, Bronfenbrenner's (1979) conceptualisation of 'ecological validity' demands that the procedures and processes of research should 'fit' with what is being studied from the participant's perspective. Here Bronfenbrenner's definition of ecological validity as "the extent to which the environment experienced by the subjects in a scientific investigation has the properties it is supposed or assumed to have by the investigator" (1979, p.29) requires that it is essential to take into account how the research situation is perceived and interpreted by the participants of the study. However, even if research is undertaken collaboratively, with participants given the opportunity to

comment on and correct any interpretations by the researcher, Bronfenbrenner warns that there is “inevitable phenomenon of idiosyncratic perception based on past experience and internal states hidden from the observer” (1979, p. 32). Similar to the discussion of response error (see Section 2.2.5), this highlights the need to pay attention to an individual’s idiosyncratic response modes. Further, Bronfenbrenner’s formulation of ecological validity indicates that if change in therapy is conceptualised by researchers as containing non-verbal and non-cognitive components, then the methods used in a study need to be seen by participants as allowing these aspects of change to be expressed.

3.3 Willi’s ecological psychotherapy and the personal niche

The influence of Lewin and Bronfenbrenner can be seen in the work of Jurg Willi and his formulation of ecological psychotherapy (Willi, 1999). Having worked as a couples and family therapist for many years, Willi developed an ecological model of therapy which brings a focus to people’s interaction with their environment rather than the autonomy of the individual. In this model, people are seen to co-construct their environmental spaces in such a way that it allows them to maintain and develop themselves psychologically. Rather than personality being inherently ‘of’ the individual, it is seen as a side effect of the continuing process of interacting with the psychological environment. Instead of looking at internal psychological structures, ecological psychotherapy concentrates on the external structures that individuals themselves create, and on how a person interacts with these.

3.3.1 The personal niche

Willi (1999) proposed the concept of the ‘personal niche’ defined as “an individual’s working space in the environment. It includes the totality of the relationships with animate and inanimate objects actually present in the surroundings. The person selects a portion of the field as a working space and creates objects for interactive effectiveness.” (p. 26). Here Willi is describing how people generally function within a portion of the whole available field, that we create a loosely boundaried subset of our life space to operate in on a day by day basis. In this regard, the personal niche is similar to Bronfenbrenner’s conceptualisation of the ‘micro-system’ within the general ecological environment (see section 3.2.1 above). Willi, however, narrows this conceptualisation further by specifically excluding anything that does not have an actual interactive effect on the person – “Imagined or internalised relationships with people or objects that are not available in reality are not part of this niche.” (Willi, 1999 p.26). Similar to Lewin’s axiom “What is real is what has effects” (Lewin, 1936 p.19), Willi qualifies what he means by ‘real’ as “Effects are real when they create facts and leave traces which have perceptible consequences for other people.” (Willi, 1999 p.27).

This distinction is important in bringing attention to the interactive nature of the personal niche. Similar to the concept of a biological niche, the personal niche is seen as a portion of the psychological environment with which the person is intimately connected and 'at home' in - "Niches contain the objects of real and current interactions, against which individuals assess their own reality and receive responses to their effectiveness." (Willi, 1999 p.26). The person both shapes and is shaped by this space in a continual dynamic process, constantly checking out their interaction with the environment, receiving feedback which directly influences their perception and response to the environment - "the personal niche changes continually over time. Individuals are constantly choosing, shaping, and creating for themselves the niches, which in turn form the guidelines for further development over time" (Willi, 1999 p.33).

3.3.2 A supplement to internal constructs

Rather than the personal niche being a replacement for other inner personal psychological constructs such as Rogers' (1951a) perceptual maps (see Section 3.4) or Kelly's (1955) personal construct theory etc, Willi sees the concept of a personal niche as supplementing these ideas. Inner personal constructs are seen as the patterns or templates through which we perceive and organise our world. By comparison, the personal niche is seen as the template through which the external world enters and is perceived by the individual - "Personal niches impose an order and structure on the external surroundings. They make the surroundings familiar and provide a sense of belonging" (Willi, 1999 p.31). In this way, the portion of the environment an individual chooses to interact with is seen as deeply significant to and intimately linked with the person's psyche. We make our 'home' in the world in such a way that it allows us to function in line with our internal personal constructs - "In accordance with his motivational schemata or constructs, a person constantly seeks definitive environments to configure his personal niche and to have an effect on objects and to receive a response from objects" (Willi, Frie, & Gunther, 2000 p.228).

Willi, however, highlights an important difference between the two concepts - while the inner personal constructs of an individual are private and can be altered or restructured by that individual alone, the personal niche is a shared space, and can not be changed at will. Though a person may alter their internal symbolisation of an object, person, or event, this will not directly change the nature of it, especially for others sharing the same space. A person may want to forget about an argument with a partner, but for the partner, the incident may still have real significance. Within the shared space of the relationship, the person is not free to live in their own personal world, but must find a way to interact with another. In this way, an individual's personal niche is never a simple reflection of a person's internal personal constructs, but rather represents a complex negotiation between the psyche of the individual and the environment.

3.3.3 Interactive effectiveness and therapeutic change

The key concept used by Willi to describe the nature of a person’s interaction within their environment is ‘interactive effectiveness’ – “Each person endeavours to influence the environment and to get a response to that influence. I call this experience of shaping the environment in interaction with the feedback received ‘interactive effectiveness.’” (Willi, 1999 p.IX). Action and feedback create a cycle of interactive effectiveness. A person initially interacts with another on the basis of their internal constructs. The ‘other’ reacts and responds to the person according to their own internal constructs. The person perceives and assesses these responses as more or less effective, then integrates and adapts to this assessment before beginning the cycle again.

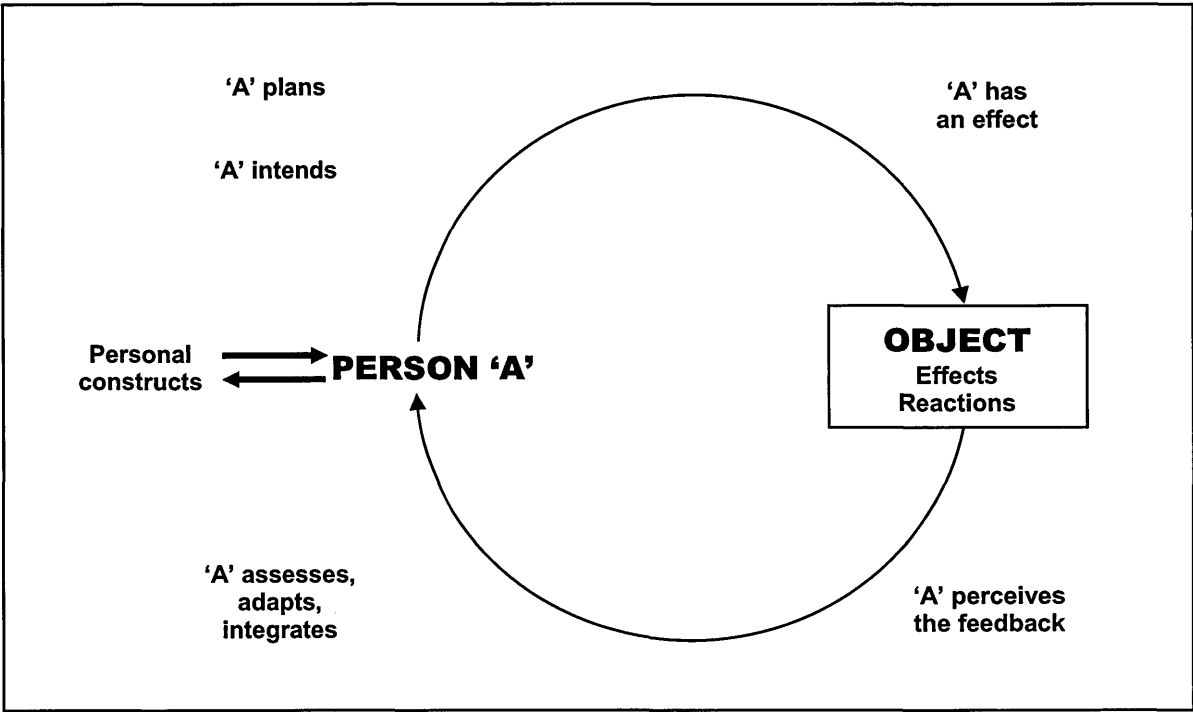


Figure 3-4 Willi’s ecological cycle of interactive effectiveness (Willi, 1999 p.18)

For Willi this interactive effectiveness is seen as a fundamental principle in behaviour. People desire to be effective within their environment, and are afraid of being seen as ineffective. ‘Successful’ people are “able to utilise their environment and can grow and succeed in it. They understand what their environment has to offer, and feel confident in their relationship to it” (Willi, 1999 p.14). This creates a positive cycle of interaction in which a person’s actions are met with concrete evidence of their effectiveness, leading to greater confidence. In contrast, unsuccessful people are ineffective at interacting with their environment - “A vicious circle easily develops: the more insignificant an individual’s effects on objects, the more he will receive negative responses, the more he will be offended, the less he will be able to make allowances for negative responses, and the more inadequate his effectiveness will be” (Willi et al., 2000 p.228).

3.3.4 *The personal niche, interactive effectiveness, and therapy outcomes*

With regards to the outcome of therapy, the aim of Willi's ecological approach is to enhance a person's interactive effectiveness such that they can be more successful in creating a supportive personal niche. Rather than treating someone's 'social dysfunction' by assertiveness training, or facilitating the person to be free from the expectations or approval of others, ecological therapy embraces feedback from others as an essential element of interactive effectiveness. "In ecological psychotherapy, we seek *above all to improve the patients' capabilities for forming relationships, on the grounds that individuals find the best conditions for developing and finding themselves by actively interacting in relationship to others*" (Willi, 1999 p.15, italics in original). This aim is not just to benefit the person in therapy, but also the significant others in a person's life, such that their shared niche 'coevolves' into a more supportive, interactive environment.

In this sense, the desired outcome of therapy is seen as more than a change in a person's internal constructs, but concrete, real effects within a personal niche. For Willi, self-realisation is more than 'finding oneself'; it requires concrete effects "that make a person visible and recognizable to himself and to others" (Willi et al., 2000 p.228). Only by actually seeing these effects manifest does a person fully realise their effectiveness, and so grow and develop – "To be responded to in recognition of one's effectiveness has a central importance for the development and maintenance of the ego... for the feeling of self-esteem and personal identity" (Willi et al., 2000 p.228). From this perspective, it becomes important to identify specific, concrete 'effects' of therapy in a person's personal niche for therapy to be considered effective. This highlights an inadequacy in using Lewin's developmental model discussed above for evaluating the outcomes of therapy. In addition to considering *differentiation, restructurization, changes in time perspective*, and changes in the degree of *reality/irreality* of a person's perception of their life space, it would be necessary to consider the actual content of the life space and effectiveness of a person's interaction with significant elements of this.

As an example of this shift in conceptualisation of outcomes, the restructurization achieved in the discussion of Lewin above by a person with depression who realises "*my 'dark and hopeless' feelings are linked with my feelings of being 'isolated and alone' which I can now see are associated with my memories of being abandoned as a child*" would be insufficient on its own. Rather, this would need to be accompanied by actual changes in interaction with significant others, such that the 'insight' facilitated 'real' changes in the personal niche. Here an indicator of 'good' outcome would be evidence of more social interaction, of adapting the personal niche to include more opportunities to engage with others, not just a change in perceived isolation or reduction in intensity of feelings of loneliness.

3.4 Rogers' client centred approach and the phenomenal field

Around the same era that Lewin presented his ideas on field theory, Carl Rogers formulated an approach to therapy which placed an emphasis on attending to the client's 'phenomenal field' (Rogers, 1951a). This 'client centred' approach emerged from a decade of practice, research and reflection on the use of a non-directive approach to counselling which had as its hypothesis:

Effective counseling consists of a definitely structured, permissive relationship which allows the client to gain an understanding of himself to a degree which enables him to take positive steps in the light of his new orientation. (Rogers, 1942 p.18 italics in original)

At the core of this approach was a "deep respect for the growth potentialities of the individual" (1943 p.285), that given the right conditions, a client's natural tendency was toward positive, self initiated action (Rogers, 1940; 1942). Here can be seen the beginnings of key concepts of client centred therapy including what Rogers was to later formulate as the 'actualising tendency' (Rogers, 1959) and the six 'necessary and sufficient' conditions of therapeutic personality change including empathy, congruence and unconditional positive regard (Rogers, 1957).

3.4.1 *The phenomenal field*

Though Rogers explicitly acknowledged his debt to Lewin (Rogers, 1947), he never referred directly to the terms 'Field Theory' or 'Life Space'. Even so, these concepts are clearly evident in Rogers' propositions of personality and behaviour (Rogers, 1951a). Like Lewin, Rogers considered a person's own frame of reference as key to understanding behaviour, and conceptualised the person in the centre of a phenomenal field. In his statement of "A theory of personality and behavior", Rogers (1951a pp.481-533) presents 'nineteen propositions' regarding the nature of the individual. Embedded within these are numerous references to this 'phenomenal field'.

Rogers' (1951a) first proposition states that "*Every individual exists in a continually changing world of experience of which he is the center*" (p.483) followed by the second proposition that "*The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, 'reality'.*" (p.484). In the third proposition Rogers (1951a) states that "*The organism reacts as an organized whole to this phenomenal field*" (p.486) and that "an alteration of any part may produce changes in any other part" (p.487). Similar to Lewin's differentiation between the outer external life space and the inner personal life space, Rogers (1951a) states in his eighth proposition that "*A portion of the total perceptual field gradually becomes differentiated as the self*" (p.497) and in his ninth proposition that "*As a result of interaction with the environment, and particularly as a result of environmental interaction with others, the structure of self is formed – an*

organized, fluid, but consistent pattern of perceptions of characteristics and relationships of the 'I' or the 'me', together with values attached to these concepts" (p.498).

Within these propositions, Lewin's (1936) formulation of behaviour as a function of the interaction between the person and the environment ($B=f(E,P)$) is clearly seen. The difference between Rogers and Lewin appears to be one of emphasis. Lewin focused on the interaction between a person and the environment, stressing that behaviour could only be understood in context. This could be interpreted as looking from the outside in, as a social psychologist seeing the individual influenced by his environment, and hence attempting to explore the dynamics of this influence. Rogers, on the other hand, was looking more from the inside out, as a psychotherapist interested primarily in how clients perceived their world. In this regard, Rogers' theory focuses more on the individual's inner personal dynamics and less on the environmental factors of personality and behaviour.

3.4.2 The importance of the client's frame of reference

Like Lewin, Rogers highlighted that it is the field as it is *perceived* rather than some 'objective reality' which is important. This is emphasised in Rogers' (1951a) seventh proposition that "*The best vantage point for understanding behavior is from the internal frame of reference of the individual himself*" (p. 494). Again, similar to Lewin, Rogers (1951a) believed that only by basing psychology on the concept of the phenomenal field could the 'science' of psychology be furthered – "the possibility of utilizing the phenomenal field of the individual as a significant basis for the science of psychology appears promising. There can be agreement on the specific way in which the world is experienced by the individual, and his behavior follows definitely and clearly upon his perception. Consequently, with agreement possible on the datum of science, science can conceivably grow" (p. 495).

However, Rogers (1951a) also highlighted the challenge for psychology in gaining access to this 'datum' – that the internal world of experience of an individual is intrinsically out of reach of 'another', and can not be directly measured or 'known' to science. Access to this internal phenomenal field is largely limited to what can be consciously related - the perceptions and experience of an individual that they are conscious of. A person can not relate what they are not conscious of, and the greater the area of experience not in consciousness, the more incomplete the picture. Rogers believed that the more one tries to infer what is present in the phenomenal field of another, but not in their consciousness, the more complex grow the inferences until the interpretation of an individual's unconscious experience can become more an illustration of our own projections. Further, knowledge of a person's frame of reference depends largely upon communication, in one form or another, which is never perfect. Hence our view of another's experiential world is always 'clouded' in one way or another, either by lack of detail or from the distortion of our own projections.

3.4.3 Perceptual reorganisation as an outcome of therapy

In his paper “Perceptual reorganisation in Client-Centered Therapy”, Rogers (1951b) observed that clients often report they have come to ‘see things differently’ after attending therapy. Rather than assuming these kinds of statement to be loose descriptive analogies, Rogers considered that literal changes in perception of the environment and of self may result from therapy. To illustrate this, Rogers used a clinical example where after a moment of insight in their therapy a client exclaims “Say, what happened to the room? ... It suddenly got lighter, like if there was a fog or a mist and an opening, and it got bigger, and the fog lifted and the mist disappeared” (p.308). From this and other examples from practice, Rogers postulated that “there is clinical evidence to suggest that perceptual reorganization takes place in some clients, and that this reorganization has a general quality to it, in that it is not merely a change in the objects or persons perceived in the therapeutic hour, but appears to affect the perception of the world at large” (p.309).

To support his theory, Rogers referred to research by Jonietz (1950) which investigated the changes in clients’ perceptions from before until after therapy using the Rorschach Inkblot projective test (see Section 2.4.2). Here the Rorschach was being used more as a source of ‘unstructured stimuli’ rather than being interpreted for the unconscious meaning it revealed. As such, rather than scoring the Rorschach using standard diagnostic methods, Jonietz examined the changes in basic ‘percepts’. Jonietz (1950) investigated these perceptual changes for 12 participants from before until after a series of therapeutic interviews, and again at 6 to 12 months follow-up (for 6 participants). These changes were compared to a comparable control group who did not experience any type of intervention. The results of the study showed significant differences between the two groups, with the therapy group demonstrating many more changes in ‘percepts’ than the control group. Further, Jonietz explored the variation within the experimental group, and identified that participants who demonstrated the most changes in their ‘percepts’ were also judged by counsellor evaluation to have improved more over the course of the therapeutic interviews. Interestingly, Jonietz also attempted to analyze the trends in these changes in perception. She reported that there were an increased number of human figures perceived in the inkblots, an increase in the number of sexual percepts, a decrease in the number of static percepts, a decrease in the number of perceptions in which something was being done to the passive subject of the percept, and a decrease in the percepts in which abstractions or inanimate objects were perceived in action. Jonietz concluded that these changes in perception implied that individuals in therapy became less repressed and less fearful, and felt more adequate and capable of handling their problems.

From this study, Rogers (1951b) concluded that change and reorganization of visual perception does occur during psychotherapy, and that these changes affect general perception and do not stop with the completion of therapy. Within his paper, the general qualities of this reorganisation can be

discerned. Primarily, Rogers postulates that perception becomes reorganized in the direction of fitting more closely the raw experiential aspects of the human organism, that perceptions of many experiences which were previously denied become available. Using Rogers' theoretical terms, it "involves more accurate symbolization of a much wider range of sensory and visceral experience" (p.323). Additionally, perception becomes more differentiated, such that subtle differences in stimuli are able to be discerned. Similarly, there is more tolerance for ambiguity such that conflicting experiences will be perceived and symbolised accurately rather than being distorted. Generally there is a sense of perception being more 'fluid', that a decrease in perceptual rigidity allows sensory evidence to be interpreted and perceived in a greater variety of ways.

3.4.4 Studying the outcomes of therapy from the client's frame of reference

Rogers' exploration of the change in perception as an outcome of therapy presents an interesting challenge to researchers. Rogers writes that "We live in a perceptual 'map' which is never reality itself" (Rogers, 1951a p.485), that we symbolise our existence, but this symbolisation is forever changing. This reinforces the need to consider ways of investigating the outcomes of therapy which 'fit' with the potentially fluid nature of this changing perception. As has already been highlighted in the section on the limitations of standardised self report questionnaires in the literature review, traditional outcome study designs are not well suited to situations where the client may quite literally 'see' a questionnaire very differently from before to after therapy. Hence to investigate the types of outcome which Rogers hypothesised, methods are required which allow the changing 'dynamics' of a client's perception to be a substantive part of the research method rather than something that needs to be 'controlled for' and preferably eliminated.

Perhaps most significantly, Rogers highlighted that regardless of the adequacy of any attempt to measure it, a person's psychological world can only be known, in any complete or genuine sense, by the individual themselves (Rogers, 1951a). With regard to outcome research in counselling and psychotherapy, this underlines the need to avoid making simplistic interpretations based on minimal sets of data. Rogers' stance encourages researchers to find ways of investigating the outcomes of therapy from the client's own frame of reference, while at the same time reminding us that any attempt to do so will still be flawed. This highlights the need to take the results of outcome research tentatively, to consider how closely the research gets to the client's own frame of reference rather than making assumptions based on other's external criteria. For example, questions in an outcome questionnaire may be straight forward and 'obvious' to a researcher, but may well be ambiguous or be interpreted completely differently from the client's perspective. This suggests that collaborative forms of research which include the client's own evaluations of change may be more valid than objectively constructed measures which are purely interpreted by a researcher.

3.5 Client agency and reflexivity

Following Rogers, a number of contemporary authors have highlighted the need to consider the client's frame of reference more fully. What emerges in their writing is an image of clients as active, reflexive agents who utilise available resources for their own growth processes. This perception of clients has potential implications for both therapy practice and research. In particular it highlights the possibility that clients may, given the opportunity, proactively utilise research and evaluation as part of their growth process. Here, client directed therapy attempts to provide feedback systems whereby a client can become the director of their own healing process. Further, collaborative approaches to assessment and evaluation can be conducted in such a way as to be potentially 'therapeutic' in their own right. Following is a brief overview of the work of some key authors in the field of counselling and psychotherapy that exemplify these themes.

3.5.1 *Rennie's research into the client's experience of therapy*

In the 1990s and 2000s, David Rennie published a number of papers on the process of counselling and psychotherapy from the client's perspective (Rennie, 1990, 1992, 1994a, 1994c, 2000a, 2001). These papers referred to his research using a method known as Interpersonal Process Recall or IPR (Elliott, 1986) whereby clients listened to the recording of a recently completed session and were asked by the researcher to comment on anything of interest or significance that they remembered. This process was very 'client led' with the participant free to stop and replay the recording at any point to discuss what they felt was going on. At times the researcher also paused the recordings to ask about specific moments of interest to the study. These research interviews were recorded then analysed by Rennie using a form of grounded theory analysis (Glaser & Strauss, 1967) to identify and categorise emergent themes.

The core category to have emerged from these studies was what Rennie termed *client reflexivity* defined as "the client's self-awareness and agency within the self awareness" (Rennie, 1994a p.427). Here clients are seen to be actively aware of, and in control of how they engage with therapy. Participants in the study reported recognising and accepting the limitations of their therapist, forgiving the counsellor's mistakes as long as the benefits were perceived to outweigh the negatives. Further, clients actively managed their relationship with their therapist, sometimes to the point of manipulating the counsellor into making the kinds of responses they needed (Rennie, 2001). These covert processes remind us that "what the client says in therapy does not necessarily reflect what he or she is thinking" (Rennie, 1992 p.229). Of particular interest, Rennie found that the participants in his study were often silently deferential to their therapist, outwardly agreeing or going along with what their counsellor was saying while internally thinking very differently (Rennie, 1994a). This deference seemed to occur due to a combination of a person's desire to

appear to be a 'good client' as well as not wanting to be distracted from their own internal process by having to correct or confront the therapist in any way.

Rennie highlights that this hidden quality of a client's reflexivity has a number of implications for therapy research. The amount of unspoken activity going on for clients during sessions means that research which does not tap into this reflexivity will result in either an incomplete or misguided understanding of the process of therapy (Rennie, 1992). In terms of therapy outcome research, a similar statement could be made. Unless researchers can find a way to tap into this reflexivity, only the outer 'face' of therapy outcome will be known. The inner qualities and reflexive nature of 'change', and the meaning this has for clients will remain hidden from view. Even more concerning, incomplete or inaccurate inferences about the outcomes of therapy may well be drawn.

Further, Rennie (1992) draws attention to the potential for the client deference identified in therapy sessions to be present within the researcher process itself. Here it needs to be remembered that the 'data' of any research investigation is only ever what a participant 'allows' to be seen. Similar to the view of Rogers (1951a) above, we can never gain direct entry to a person's inner thoughts and feelings. This is true of either quantitative or qualitative enquiry, that participants are quite capable of presenting an 'acceptable face' and even an outright fabrication, be it on a questionnaire or in an interview. Even when there is no overt intention at misrepresentation, the desire to be a 'good participant' may well silence or distort a participant's responses despite the researcher's best efforts to guard against this. Rather than seeing this as a source of 'error', it would perhaps best act as a reminder that all results from research are the product of an active, reflexive and selective process encompassing participants and researchers alike.

3.5.2 Bohart and Tallman on the client as the active change agent

Similar to Rogers (1957), Bohart and Tallman (1996; 1998; 1999; Tallman & Bohart, 1999) believe that clients do not need an 'expert' therapist to diagnose or intervene, but rather to provide a proper 'environment' whereby the client's own active self healing processes can function. From this perspective, therapists are "guides or aides, or sometimes nothing more than witnesses to the process" (p.181). Here it is the client who is the primary change factor, that they are seen as an active, agentic self-healer capable of making creative, spontaneous contributions to their own growth process. Similar to Rennie above, Bohart and Tallman (1999) add that these creative client processes go beyond what the therapist has to offer, potentially making use of unhelpful or even hindering experiences to further their own growth process. In this sense, clients are seen to actively take what is beneficial to them from therapy, leaving what is unbeneficial behind or even converting it into something worthwhile by 'turning lemons into lemonade'.

In this model, clients are seen as active learners, taking what the therapist has to offer and ‘trying it on for size’ to see if it fits. If something does not fit quite right, clients are capable of modifying it to ‘do the job’. This is seen as an active process of constructing and creating new perspectives and meanings, including constructively misinterpreting comments by the therapist, and even subtly shaping the therapist to get what they want. Here links to Willi’s (1999) conceptualisation of the personal niche can be drawn, whereby the therapist can be seen as just another ‘object’ in the client’s niche. From this perspective, the client chooses, shapes, and actively creates the ‘working space’ of therapy. Indeed, therapy becomes just another place within which a client interacts, and could be seen as most beneficial when it allows or affords a client to experience greater ‘interactive effectiveness’. Rather than the therapist ‘treating’, ‘teaching’, ‘intervening’ or in any other way ‘shaping’ the client, what becomes important is the therapist’s willingness to be ‘shaped by’ the client, to be moulded into a useful tool (Rodgers, 2002) with which the client can utilise to shape other ‘objects’ in their personal niche.

This perspective has a number of implications for researching counselling and psychotherapy. Not only does it imply that further attention needs to be given to researching how clients help themselves, how they implement and develop what is learnt in therapy, the contextual factors that contribute to the maintenance of client problems, and the contextual factors that inhibit or facilitate self-healing (Bohart & Tallman, 1999), but also to consider how client’s are actively involved in and make use of the research itself (Rodgers, 2003). Here it can be argued that ‘good’ research has the potential to be a further resource which clients can utilise in their self healing process. As such, effort needs to be directed towards investigating the actual methods themselves, and to consider how they allow clients to make use of them. Rather than the research method being seen as an objective and independent activity, consideration as to how different methods afford different forms of interaction becomes significant.

3.5.3 Hubble, Duncan and Miller on client directed therapy

Taking into account Bohart and Tallman’s view of the active, agentic client, Mark Hubble, Barry Duncan and Scott Miller call for counselling and psychotherapy to become ‘change’ focused rather than ‘therapy’ focused (Hubble, Duncan, & Miller, 1999; Miller, Duncan, & Hubble, 2005). By this they mean that rather than focusing on how a particular therapy works, research and practice should instead be orientated towards what the ‘customer’ wants – i.e. change. Hubble, Duncan and Miller draw on the ideas and thoughts of Levitt (1975, cited in Miller, Duncan, & Hubble, 2005) who demonstrated that numerous industries in America suffered dramatic reversals in fortune from becoming ‘product’ orientated rather than ‘customer’ orientated. When industries such as the railroads and Hollywood failed to adapt to meet changing customer needs, there was an inevitable dramatic decline in demand. Miller et al (2005) apply this logic to the field of counselling and psychotherapy and contend that the field’s longstanding debates between different approaches to

therapy is equivalent to being ‘brand’ focused rather than client focused. Rather than being interested in what clients really want, which is ‘change’, the field has focused on the therapies themselves. Endeavours such as defining empirically supported treatments (ESTs) and evidence based practice collude with what Miller et al (2005) quote Levitt as saying “the illusion is that continued growth is a matter of continued product innovation and improvement” (p.85). Rather than this focus on the ‘product’ of therapy, Miller et al (2005) contend that the field should be looking at “whether consumers experience the changes they desire *whatever the means*” (p.85, italics in original).

Miller, Duncan and Hubble go on to illustrate an approach to therapy which encompasses this ‘change focus’. Their approach uses continual feedback and input from the client to ensure that the therapy continues ‘on track’. This is similar Lambert et al’s (2001) ongoing treatment monitoring process mentioned in the discussion of practice based outcome measures (see Section 2.1.4). Rather than being concerned with the therapist’s techniques or modalities of practice, the approach focuses on providing both therapist and client with a mechanism for monitoring the ongoing progress in treatment. Specifically, a brief four item Outcome Rating Scale (Miller et al, 2003; see Section 2.1.6) is completed as the beginning of each session and discussed between therapist and client. Additionally another brief four item Session Rating Scale (Duncan et al., 2003) is completed and discussed at the end of the session to monitor the therapeutic relationship. Here the therapist is free to use whatever approach they feel is most relevant – the key is to continually ‘check in’ with the client and respond to the feedback given. From this perspective, the ‘role’ of the client is recast to that of the “leading character... given full editorial and directorial control of the action as it unfolds” (Duncan & Miller, 2000a p.185).

In terms of the significance of a client directed approach to the study of therapy outcomes, the focus taken by Miller, Duncan and Hubble can be seen to shift the balance from constructing measures that are ‘valid’ in strict scientific terms, to finding ways to best hear the client’s feedback. Here the emphasis is placed on methods that allow clients to ‘voice’ themselves more effectively. This is significant as from Rennie’s (1994a) study it is clear that clients tend to defer to their therapist rather than voice their concerns. Additionally, previous experience by Duncan and Miller (2000b) of trying to implement informal feedback demonstrated that therapists routinely failed to ask clients for their input. Without a structured, systematic approach to feedback, there is greater likelihood that clients will not express their concerns, and more likelihood that therapists will not ask (Miller, Duncan, & Hubble, 2005). In contrast, with a formal feedback process in place, clients can ‘tell’ the therapist things without having to confront them directly. Key to this is finding methods that are feasible and viable both in terms of assisting clients to ‘speak’, and enabling therapists to ‘listen’.

3.5.4 Fischer on collaborative, individualised assessment and evaluation

A further consideration of seeing clients as active, reflexive agents entails *how* assessment and evaluation is conducted. Irrespective of the actual method used, Constance Fischer encourages practitioners and researchers to embrace a collaborative, individualised approach (Fischer, 1970, 1973, 1979, 1989, 1994, 2000, 2001, 2006a, 2006b). Instead of focusing on *what* method is most appropriate, Fischer contends that it is the *way* a practitioner or researcher uses the method which is most significant. Rather than ‘extracting data’ or ‘eliciting responses’, the practitioner/researcher and client are seen to ‘co-labour’ together to develop a productive understanding of the individual (Fischer, 2000). Whichever method is employed, be it quantitative questionnaire, qualitative interview, projective technique etc, it is seen as a *bridge* into another person’s life and a *tool* to aid further exploration. Here there is a sense of working together, using whatever methods are at hand to explore the client’s ‘life world’ more fully.

This approach acknowledges that all assessment and evaluation is ‘contextualised’ (Fischer, 1994). Fischer (2000) describes a process of the ‘hermeneutic cycle’ whereby current observations are informed by our previous knowledge, which in turn are influenced by current observations. Hence any ‘results’ from an assessment or evaluation are always tentative and within a specific context and moment in time. Rather than being a static, mechanical process conducted in the same way with each client, collaborative assessment and evaluation attend to the individual’s unique situation and ‘life world’. This reflects a deep respect for the autonomy and agency of the individual, as well as the complexities and ambiguities of human existence (Fischer, 2000). Further, it promotes a more active, agentic stance from the practitioner or researcher. Instead of just being a data collecting and interpreting device, it involves the researcher actively participating as a human being, drawing on their own subjectivity and personal experience (Fischer, 2006b). Here it is acknowledged that all interactions are inter-subjective and perspectival, arising from both the researcher’s and the participant’s unique biographies, histories, cultural influences, values, interests etc (Fischer, 2001).

In terms of investigating and evaluating the outcomes of therapy, the above approach encourages researchers and practitioners to become more collaboratively involved with participants. Going beyond the ‘feedback’ approach proposed by Miller et al (2005) and Lambert et al (2001) in the discussion above, this would entail actively and collaboratively exploring the client’s world ‘through’ the outcome measures used. For example, in using a standardised outcome questionnaire such as the CORE-OM, rather than just collect and statistically analyse the data a researcher or practitioner could collaboratively explore the meaning of the client’s scores. Any unexpected scores or potential concerns such as high ‘Risk’ scores could be explored more fully to gain an understanding of an individual’s responses and discussed in terms of the implications for both research and therapy. Further, the researcher or practitioner could share the interpretation of the total score in terms clinical significance and severity levels. Ongoing weekly measures could be

graphed on a session by session basis and collaboratively explored in relation to the expected 'trajectory curve' of change as well as clinical cut off levels.

The depth of this collaborative approach brings to the fore the ethical and moral dimension of therapy research and evaluation. From this perspective, research and evaluation is seen as never being a neutral event, that it is always an active intervention which to some extent will alter the experience and life of both client and researcher/practitioner (Fischer, 1973). Hence rather than attempting to be 'neutral' or 'objective' and potentially ending up being experienced as hindering, researchers and practitioners are encouraged to embrace the inevitable interventional nature of assessment and evaluation such that it is most likely a constructive, beneficial experience (Fischer, 1994). Fischer (2006b) contends that "We are least likely to be abusive, and most likely to be useful, when we regard our participants as coassessors and coresearchers. In short, collaboration in both undertakings is likely to be most constructive for all parties and to yield the most believable and useful findings" (p.354). Here Fischer proposes that researchers should be attuned to and respectful of the people sharing their lives, striving to be open to the experiences of the other while also being aware their own previous theories and understandings. Significantly, research conducted by Gale (1992) in this collaborative, interactive manner was experienced by participants as being more therapeutic than the therapy it was investigating! Though cause for concern for some (c.f. Hart & Crawford-Wright, 1999) this convergence between research and therapy is promoted by others, especially within a humanistic framework (Rennie, 1994b; Fischer, 2006a).

3.6 Peavy's sociodynamic counselling and life space mapping

Many of the above ideas and concepts can be seen to be encapsulated by an approach to therapy presented by Vance Peavy as sociodynamic counselling (Peavy, 1997, 2000, 2001, 2004, 2008a). Peavy's approach incorporates a view of the 'self' based on notions of agency, reflexivity, narrative and evolving self-organisation (Peavy, 1996). Here the focus is not on general psychological principles and processes but rather on personally derived meaning constructed through participation with others and the environment. From this perspective, counsellors become more facilitators of 'help seekers' rather than experts 'treating' a patient's dysfunctional mind. Peavy (1999b) considered that this placed counselling more as a social practice or cultural method rather than as a purely psychological activity. The sociodynamic approach draws on philosophical ideas, literary forms, and socio-cultural studies to create a new 'vocabulary' for counselling which is not constrained by the language of traditional, 'industrial age' approaches to therapy (Peavy, 2004).

3.6.1 A constructivist perspective

Peavy’s conceptualisation of sociodynamic counselling draws primarily on a constructivist view of knowledge and understanding. In contrast to a more traditional ‘modern’ view of the world which sees things in mechanistic, reductionist terms, this ‘post modern’ world view adopts a more holistic, ecological frame of understanding. Rather than seeing the world in terms of discrete cause and effect, or trying to reduce things into component parts, a constructivist view sees things in terms of patterns of interaction, of non linear, complex systems where the whole is very different from the sum of its parts. To highlight these different perspectives, Peavy summarises and contrasts them as follows:

Old World View	New World View
-Thinking-	-Values-
Ego-assertive	Social-integrative
Self-assertive	Social-integrative
Rational	Intuitive
Expansionist	Conserving
Analytic	Synthesizing
Competition	Cooperation
Reductionistic	Holistic
Quantity	Quality
Linearity, determinacy	Non-linearity
Domination	Joint action
Hierarchical	Networked
Top-down decisions	Deciding by consensus

Table 3-5 Old world view versus new world view (adapted from Peavy, 1997 p.36)

Peavy (1997) traces this perspective back to the ideas of Giambattista Vico (1725), Immanuel Kant (1781), Hans Vaihinger (1924), Frederick Bartlett (1932) and Jean Piaget (1970) who propose that the process of ‘knowing’ is also a process of ‘making’. That is, we do not just passively perceive our world, but actively mould and construct our perceptions in order to make sense of the world we live in. Indeed, from a *radical* constructivist perspective, there is no ‘reality’ other than that which we perceive. Contemporary *critical* constructivist theorists such as Michael Mahoney (1991) and Vittorio Guidano (1991), however, do not deny the existence of a concrete physical ‘reality’, but believe this external reality can never be known directly. Instead, we ‘co-construct’ personal and social realities through our interaction and interdependence with the surrounding social and physical world: “human action originates in cultural, social, communicative/linguistic processes. Through contextualised and personally meaningful acts, people produce their lives” (Peavy, 1997 p.64).

3.6.2 Counselling as a social rather than psychological activity

From this perspective, sociodynamic counselling is seen not so much as a ‘psychological’ activity, but rather a social activity. The counsellor interacts with the ‘help seeker’ in order to better ‘construct’ or re-construct the self of the other in ways that ‘fit’ or integrate with their social circumstance. As such, counsellors are not seen as psychological experts. Rather, counselling is seen as one of many cultural interactions which people in need can engage in, in order to negotiate, construct and learn from. Further, this is a bi directional activity. Rather than the expert telling the other what to do, the counsellor is also seen to be in the process of constructing their self-hood, and learning how to be successful in the interaction. As such, counselling is not well located in the world of absolutes and ‘facts’ of natural science, but would be better situated in the social-cultural world with its multiple realities, fuzzy logic and indeterminacy.

Similar to Bronfenbrenner’s (1977b) conceptualisation of the macro-system discussed previously (see Section 3.2.1), Peavy also sees that the social structure we live in has a direct and significant impact on the lives of individuals – “counsellors should view every personal trouble of the individual as indicative of a public (policy) issue and every public policy issue and policy as generative of personal troubles for at least some people” (Peavy, 1997 p.58). Here Peavy is encouraging practitioners to realise the significance of ‘macro-transformations’ and the direct impact these have on the day to day life of individuals. Though the influence of changes in the macro system may seem diffuse and unpredictable at the individual level, Peavy contends that they are never the less very real. These changes will act to constrain some individuals, while creating opportunities for others. Further, in the post-industrial era, change is occurring more rapidly and frequently and in different ways than before.

As with Willi’s (1999) interactive effectiveness discussed previously (see Section 3.3.3), Peavy (1997) sees the need for people to learn to navigate effectively in this shifting, unpredictable world. As such, we do not operate in society as experts, but draw on ‘local knowledge’ and cultural hypothesis, working with a ‘psychology of best guess’. From this perspective, the counsellor’s task would be better defined as helping people to ‘map’ possible futures, or even ‘invent’ futures, rather than trying to categorise or pigeon-hole people. Here the counsellor is seen as a ‘bricoleur’ “drawing on the knowledge at hand in the specific cultural situation of the client to help the client fashion resolutions to life difficulties which the individual is experiencing in her everyday context” (Peavy, 1997 p.27). Again similar to Willi (1999), Peavy sees the counsellor’s role as helping to bring about ‘concrete effects’ and assist people to find real solutions to practical problems in living.

3.6.3 A narrative conceptualisation of ‘self’ and counselling

Embedded within this conceptualisation of sociodynamic counselling are concepts of re-authoring, remaking and retelling aspects of a life story such that it is more meaningful and more flexible.

Peavy (1997) saw that “humans live their lives much as stories are written and told” (p.63) to the point that the stories we tell have a very strong, if not ruling influence on the lives of individuals and societies. Here there is a significant shift in conceptualisation of the person from a ‘psychometric self’ composed of various attributes, qualities, traits, variables etc, to a ‘narrated self’ constructed by the stories we tell ourselves and others (Peavy, 2004).

Stories and the language tools which are used to articulate them are not only representative of individual experience, they create personal realities and are part of the transforming processes which humans must engage in as they search for sustainable paths through culture. (Peavy, 1997 p.63)

From this perspective, the task of the counsellor is to join the ‘storyteller’ in the process of re-authoring their story toward more preferred futures. This process entails introducing questions rather than providing answers, such that new pathways of perceiving and understanding are introduced rather than bringing a ‘full stop’ to the narrative (Peavy, 1997). Here the focus is on a vocabulary of possibility and potential rather than deficit (Peavy, 2001). The aim is to assist help seekers to participate more fully and with more meaning in social life (Peavy, 1999b). The counsellor is seen to possess ‘cultural tools’ acquired from everyday life as well as ideas and knowledge from psychology, sociology, philosophy, economics, spirituality and other cultural disciplines (Peavy, 1999a). These are ‘shared’ in the counselling process with the help seeker such that they can adapt their own cultural tools to be more effective. Here the counsellor’s ‘healing stories’ can be seen to interact with and provide an alternative to a help seeker’s ‘problem stories’ such that new possibilities emerge.

3.6.4 Life space mapping as a therapeutic tool

Peavy drew extensively on Lewin’s (1936) concept of the life space (see Section 3.1.3) to describe the ‘semantic network’ within which people are embedded (Peavy, 1997, 2000). From a sociodynamic perspective, a person’s life space is considered to be an aggregate of the meaning of all the people, experiences, objects, relationships, events, and so on that a person has accrued so far in life:

A life space is like a hotel in which many voices have taken up residence. Depending upon the occasion and the orientation of the individual, different ‘residents’ may give voice. Together, the counsellor and help-seeker investigate the help-seeker’s life space and narrated selves which reside there. (Peavy, 2001 p.9)

In addition to spoken and written communication, Peavy (2008b) considered it was important to utilise other forms of ‘cultural literacy’ such as visualisation to facilitate the exploration of the life space. In particular, he saw life-space mapping as a powerful tool with which to engage all three

forms of communication at the same time: “Speaking-listening, writing-reading, and visualizing are the three principal means of making meaning, communicating, and constructing cultural sense. To watch mapping occur is an opportunity to observe the magic of a human mind mediating its objects of consciousness” (Peavy, 2008b p.1). Life-space mapping facilitates the explication of what a person considers to be the important and personally meaningful aspects of their life space with regard to their current concern, and to place different factors into association with each other. Further, Peavy (2008b) considered the life-space map not just a representation of a person’s world, but as a tool to help people actively ‘construct’ the meaning of their ‘reality’. Complex issues and situations can be clarified and simplified, structure can be introduced to counteract disorganisation, connections can be drawn between previously unrelated elements, patterns of influence can be seen to emerge in the act of creating the map, and problems and concerns can become contextualised within a wider view of life (Peavy, 2004).



Figure 3-5 Life Space Map created by a counsellor in training (Peavy, 2008b)

Peavy (1997) saw the mapping process as a cooperative venture between counsellor and help-seeker. The counsellor begins the process by inviting the help-seeker to view a blank sheet of paper as their present life space and to place themselves somewhere on it. Next the help-seeker is encouraged to use lines, symbols, images, colours, metaphors, icons, words and short sentences to 'map out' experiences, events, people, relationships, needs, voices, obstacles, possibilities and other information. As well as asking questions and discussing the various features of the map as they are drawn, the counsellor may also at times directly contribute to the content of the map. In this way a sense of 'working together' is achieved such that the counsellor is able to get an 'insiders view' of the life space of the other.

3.6.5 Constructivist perspectives on the study of therapy outcomes

Peavy's conceptualisation of counselling and psychotherapy as a socially constructed process has a number of implications for therapy outcome research. In particular, Peavy (Peavy, 1997 p.39-44) set out a number of principles which he believed encapsulated the influence of constructivist thinking on the practice of counselling:

1. There are multiple realities, rather than one true, objective reality.
2. People live in a social world which is 'co-constructed' through interaction, communication and inter-relating.
3. Language is the key 'meaning-construction' tool.
4. Ongoing life-experience, as it appears through performance, and as it is expressed as personal meaning, is the medium in which counselling is rooted.
5. 'Self' is a complex, evolving, multi-voiced configuration of meaning, a metaphorical way of referring to the subjective sense of who we are.
6. Individuals are always situated, or socially located, in a specific context and thus will give voice to their concerns from that particular perspective.
7. Counselling is a culture-centred activity

These principles can also be seen to have a number of implications for the process of researching the outcomes of counselling and psychotherapy. Rather than attempting to quantify an 'objective reality' of a client on a standardised questionnaire before and after therapy, these principles can be seen to encourage researchers to use 'meaning construction' tools to explore a client's changing life-experience and complex configurations of meaning. Rather than defining participants as cases, categories, diagnoses, stereotypes or classifications, research methods should allow multiple 'voices' to be heard and deal directly with ongoing life experience as it is enacted. Here there is acknowledgement of the agency of the client, and the importance of viewing outcomes from the individual's own internal, reflexive frame of reference. Additionally, the research process is seen to actively co-construct the meaning of the outcomes of therapy for a client. Here therapy outcome research is more of a joint venture whereby both researcher and participant gain greater

understanding. Further, there is an acknowledgment of changing 'context', that a person will be 'situated' differently at the end of therapy compared to the beginning. As the context changes, so will a person's 'story' change, hence methods that 'hear' this change of story are required.

Finally, and perhaps most significantly, the research endeavour itself can be seen as a culture-centred activity, with its own 'rules' of interaction which are embedded in cultural templates. Here the research process becomes a specific form of dialogue which 'allows' a certain type of communication 'appropriate' to that context. Different approaches to research afford different forms of communication. For example, the request to complete a standardised outcome questionnaire such as the CORE-OM can be seen to initiate a dialogue between the questionnaire items and the participant, where a culturally acceptable response is to mark a single item on the response scale of 0 to 4. There is tacit cultural agreement that responding halfway between two response points (e.g. 2.5) is unacceptable, even if this 'fits' better from a participant's perspective. Similarly, a post-therapy qualitative interview is typically culturally constructed such that the expected focus will be on some aspect of the outcome of therapy. Casual conversation about what a participant was planning on doing later that evening, where they were going and what they were planning to wear would probably be seen as highly inappropriate, even if this was foremost in a person's mind. Hence the research method itself intrinsically 'constructs' what 'comes out' of the process, and hence our view of the outcomes of therapy. To obtain a fuller picture of the variety and nuances of the outcomes of therapy, a variety of methods are required which enable different forms of dialogue to take place.

3.7 Implications for the present study

From the above, it is clear that the approach undertaken in the present study is not 'new'. Rather the study is an attempt to bring together some of these ideas to construct a slightly different 'lens' through which to view the outcomes of counselling and psychotherapy. The following sections highlight the key implications from each of the above concepts for the present study.

3.7.1 Implications of Lewin's field theory and the life space

Lewin's concept of field theory and the 'life space' provides a cornerstone for the present study. In particular, the study develops a method that can be used to look at the outcomes of therapy in relation to a tangible representation of a client's 'life space' in the form of a Life Space Map (LSM). This falls far short of Lewin's call for psychology to embrace a more Galileian view of the world for studying the underlying 'dynamics' of change. Rather, it is an initial attempt to provide a method which can be used to consider change from a more holistic perspective and which considers the client not in isolation, but as embedded in a complex social world. Here Lewin's

dimensions of development of the life space (*differentiation, restructurization, changes in time perspective, and changes in the degree of reality/irreality*) may provide an alternative construct for evaluating the outcomes of therapy compared to current methods which typically focus on symptom reduction, increases in wellbeing or functioning etc. Further, the process of constructing a tangible representation of a client's 'life space' may help to bring a focus on the 'between-ness' of problems and issue, such that they are not to be seen solely 'of' the person. Indeed 'putting it down on paper' may promote what in the narrative therapy tradition is termed 'externalizing of the problem' such that "the problem becomes a separate entity and thus external to the person or relationship that was ascribed to the problem" (White & Epston, 1990 p.38).

3.7.2 Implications of Bronfenbrenner's ecology of human development

Bronfenbrenner highlights the complexity and multitude of influence of the 'ecological environment' on any process of human development. Though limited from an ecological perspective on many levels, the present study can be seen as a small step in the direction of attempting to take into consideration a client's wider ecological environment. Drawing on Bronfenbrenner's conception of the 'micro system', it attempts to explore the changes in the perceived content of this as a function of a participant's exposure to and interaction with a 'therapeutic environment'. In these terms, the study does not try to isolate counselling and psychotherapy as a specific change factor, but rather attempts to place this activity within a much more complex, interdependent system of influence. This decentralises the significance of therapy and places it more as one of many 'resources' that a client can utilise for their continued development.

Further, Bronfenbrenner's approach to ecological validity highlights the significance of participants' 'idiosyncratic perception' and 'internal states' which are often hidden from the observer. With regard to therapy outcome research, the Life Space Map can be seen as a method which potentially allows some of these hidden aspects to be brought into awareness for the participant and revealed to the researcher. From this perspective, the method can be seen as an improvement in ecological validity over interviews alone, especially if the 'environment' of a study is considered to include both the verbal and non-verbal 'world' of the client. As highlighted in the discussion of visual self report methods (see Section 2.4), the tendency has been for researchers to privilege the use of numbers and words associated with the left hemisphere of the brain. Given that counselling and psychotherapy most likely engages both hemispheres of the brain, it seems important to 'hear from' the more non-verbal right hemisphere of the brain when considering the outcomes of therapy.

However, Bronfenbrenner's definition of ecological validity also cautions on making assumptions that the 'environment' experienced by participants is the same as that perceived and interpreted by

the researcher. In the present study, if this environment is seen as analogous to the ‘life space’ of the client, the danger for researchers using the Life Space Map to investigate the outcomes of therapy is in making any assumption that their interpretation of the ‘map’ is the same as the client’s. In the present study, care has been taken to not privilege the researcher’s interpretation of the Life Space Maps, but rather to focus on the participant’s own interpretation and understanding of their maps and the changes from one map to the next. Further, participants’ views and feedback on the usefulness of the methods used for evaluating change were explicitly sought in order to gain an understanding of how the methods were *actually* experienced compared to how they were *intended* to be experienced by the designers of the methods.

3.7.3 Implications of Willi’s ecological psychotherapy and personal niche

From the perspective of Willi’s ecological psychotherapy, the current study can be seen as an attempt to construct a visual representation of the ‘personal niche’ that a participant has selected to interact with. In line with Willi’s assertion that a personal niche contains objects of real and current interactions, the Life Space Map can be considered an actual ‘map’ of these ‘real’ objects. This subtly shifts the view of the outcomes of therapy from being purely psychological to also incorporate practical, ‘real’ change in a person’s life. From Willi’s perspective, it would not be sufficient for change to just be ‘perceived’, it would also need ‘concrete effects’ such that the person experienced themselves to be more effective in their interaction with their personal niche. By considering the method presented in the present study as an actual ‘map’ rather than purely as a form of self expression, there is an opportunity to consider and explore ‘real’ changes in a person’s life space from before to after therapy. Further, this potentially creates a focus point for discussion of a person’s ‘interactive effectiveness’ within their personal niche, as well as how a person has adapted to and ‘shaped’ their niche to offer greater opportunities to interact more effectively with others.

3.7.4 Implications of Rogers’ client centred approach

A key influence of Rogers’ client centred approach to the present study is the need to consider the client’s own frame of reference when investigating the outcomes of therapy. Rather than impose external interpretations or criteria on the ‘success’ or ‘failure’ of therapy, or even on what should be viewed as significant elements or aspects of change, the client’s own criteria and reflections on the important outcomes of their therapy have been sought. From this perspective, the Life Space Map can be seen as a highly customisable method which can be adapted to the needs of each individual. Further, rather than assuming a static frame of reference from before until after therapy, the proposed method allows for participants to completely change how they represent their ‘life space’ at different stages of the study. No restrictions on the form or structure of their

representation are imposed. Hence this can be seen as an attempt to honour the client's changing symbolisation from one moment to the next.

The Life Space Map approach can also be seen as an attempt to draw directly on the concept of a changing 'perceptual map' as discussed by Rogers. It is an opportunity for participants to 'project' how they see themselves and their situation on to paper, and to reflect on how their perception of life has changed over time. This may provide an opportunity to consider change more directly in terms of the qualities that Rogers discussed above. For example, participants may be able to 'see' things retrospectively in their Life Space Map that were previously unavailable to their awareness. Similarly, participants may become aware of how distorted their previous view of things was, or of how rigid and inflexible their perception of life was. Rather than rely on preformed criteria in the form of a questionnaire, the unstructured visual stimulus of the Rorschach, or purely retrospective recall, the proposed method allows participants literally to 'see' how their perception of their life has changed from before to after therapy.

3.7.5 Implications of client agency and reflexivity

The themes of client agency and reflexivity have had a central influence on the present study. In some ways similar to Rennie's use of IPR, the approach taken is very 'client led' with the participant taking the lead in highlighting and discussing aspects of their Life Space Map. Further, the visual nature of the method is designed to go beyond the outer 'face' of therapy outcomes, to attempt to 'reveal' the hidden qualities of change which are implied by Rennie's research. Additionally, the Life Space Mapping approach is intended to tap directly into a client's reflexivity as the primary mechanism for evaluating change, rather than this being interpreted from an external perspective. Here, like Bohart and Tallman, clients are seen as capable, agentic beings able to make use of the tools provided in the study to help them reflect on and consider changes in their life. Further, the study utilises the client's reflexivity to consider how useful the actual methods were for achieving this.

Perhaps most significantly, the proposed method attempts to embrace the collaborative, individualised approach proposed by Fischer and apply this to the study of the outcomes of counselling and therapy. Here the creation of the Life Space Map can be considered a collaborative process, whereby the client and researcher 'co-labour' to construct a meaningful representation of the client's life space. Rather than imposing predefined criteria or structure, the method offers a 'space' within which a person can interactively 'build up' their image. The process of 'putting things down' then standing back from and 'taking it in' can be seen to be similar to Fischer's description of a hermeneutic cycle. Here a Life Space Map is not seen as a static representation, but rather contextualised as part of an ever evolving process. The act of constructing a Life Space Map is seen to emerge from experience, but also helps to shape the understanding of that experience and

give meaning to it. Hence the 'outcome' of therapy is seen to be both revealed in and created by the very act of constructing the Life Space Map. There is also an active intention that this is a beneficial experience which facilitates a person's growth process. Rather than being an 'objective measure', the aim is to complement the experiences of therapy by providing an opportunity to reflect on and contemplate what has 'come out' of counselling and psychotherapy and 'come into' a person's life.

3.7.6 Implications of Peavy's sociodynamic counselling

Peavy's theories and ideas have had a significant impact on the present study. In particular, his approach to life-space mapping as a 'cultural tool' which allows spoken, written and visual communication to take place has been central in the development of this method as a research tool. Here the method is seen as an opportunity to hear different 'voices' from participants than would otherwise be heard using standardised quantitative questionnaires or qualitative interviews alone. Further, it can be seen to be engaging of both left and right hemispheres of the brain, allowing a more holistic 'view' and incorporating 'right brain' functioning such as spatial construction, pattern matching etc (Sperry, 1973). It is envisaged that engaging in a more creative dialogue with participants about significant aspects of therapy outcome may consequently shed light on different dimensions of outcome than have previously been explored.

Further, it is acknowledged that the process of constructing a life space map is not just about obtaining a 'representation' of a person's life space, but rather an active process of meaning making in its own right. Rather than attempt to be an 'independent' measure, it is considered that all methods of research form some sort of cultural interaction which influence both researcher and participant. Different methods are seen to provide different ways for participants to 'see' themselves and make meaning of their experience. Hence the life space mapping approach will facilitate a different construction of the outcomes of therapy for participants than other methods. Further, there is potential for the method to be 'therapeutic' in a similar way to when used in a therapy setting, by clarifying and simplifying issues, creating structure and making connections, allowing patterns to be seen, and providing a holistic overview.

However, a significant difference between Peavy's approach and the approach taken in the current study is that in therapy there is an ongoing context of engagement, such that issues and problems can be 'worked with' over time. Research, on the other hand, is more of a 'one off' encounter. Hence care is needed to not 'open up' things that can not be sufficiently 'processed' in the context of the research interview. Further, the primary intent of the current research was not to explore alternative meanings, preferred futures or to create a plan for action, all of which are part of the intended use of the life space map in therapy. Hence the researcher's active involvement in the construction of the life space map was more limited than that suggested by Peavy (1997).

4 AIMS OF THE STUDY

The aim of this study is to develop a new visual method for investigating counselling and psychotherapy outcomes that is sensitive to changes in the client's frame of reference and perception of their social world. Further, the intent is to explore the participant's own experience of using the new method in comparison to a more traditional, quantitative approach. Following are the specific research questions that the study attempts to address.

4.1 Research questions

4.1.1 What happens when we investigate the outcomes of counselling and psychotherapy using collaborative methods that incorporate the client's frame of reference and self reflection on change?

4.1.2 What different 'view' of outcome can this approach to assessing the outcomes of counselling and psychotherapy yield compared to using a conventional pre/post questionnaire design?

4.1.3 How do clients feel about using a creative, visual method for evaluating the outcomes of counselling and psychotherapy compared to using a standardised quantitative questionnaire?

4.1.4 What benefits or drawbacks do people report from using the different methods for evaluating changes from therapy?

5 METHODOLOGY

The methodological approach adopted in the present study has been informed and shaped by a number of influences and conceptualisations about the meaning of what it is to conduct 'research'. The general epistemological context for the study can be characterised as broadly located within the social constructionist tradition of inquiry (Gergen, 1999; Burr, 2003). Social constructionism takes a position that social realities, and knowledge about these realities, does not comprise a set of objective 'truths', but instead consists of an on-going process of co-construction of 'knowing' that takes place between persons and within communities. A social constructionist approach to knowledge is highly sensitive to the relationship between power and knowledge, and the tendency for 'truth' to represent the voices of privileged groups within a culture (Foucault, 1979). The epistemological basis for this study has also been influenced by Fishman's (1999) account of a postmodern pragmatic approach to professional/practitioner knowledge, which argues that knowledge-for-practice needs to be grounded in concrete case examples that are written in a critically-informed manner. Finally, the research has been shaped by the person-centred approach of Rogers (1951a; 1961) which emphasises the importance of the quality of the relationship between researcher and participant (see also Gergen, 2009).

Primarily, the concept of 'bricolage' seems to describe best the process of discovering methods and ways of 'doing' the research as the study has progressed. The spirit of postmodern, social constructionist inquiry is not to adopt a set of preconceived and unified methodological rules, but to operate from a stance of evolution, adaptation, pluralism, learning and a need for pragmatism in order to 'get it done'. The following sections within this chapter aim to provide some insight to these different approaches, and the 'stance' taken in the present study. The chapter examines different aspects of the concept of methodological pluralism in some detail, before moving to consideration of the issues involved in establishing the reliability and validity of qualitative research.

5.1 The differing voices of research

It can be argued that all research is a matter of rhetoric (Bazerman, 1988) which aims to convince and persuade the 'listener'. Recently, Rennie (2007b) has outlined how different researchers employ different language and styles of writing, and call upon different traditions of research in order to justify and substantiate their own approach. Here research can be seen not as a means of establishing fixed truths or 'laws', but as a 'conversation' with others within the field, both past and present (Rorty, 1981). Each researcher chooses a selection of papers, studies, theories etc to engage with which helps to construct their own argument, and in so doing, continues an ongoing

discussion. From this perspective, the current study becomes a ‘voice’ within an ongoing conversation about the outcomes of counselling and psychotherapy.

A fundamental question for any researcher, however, is what discussion to join, such that their voice is heard and understood, rather than being ignored, misinterpreted, or shouted over. Within the world of counselling and psychotherapy research, there are many ‘camps’, each with their own style of conversing, their own agendas and aims, and their own view of what constitutes a ‘good’ argument. Broadly speaking, however, two main styles predominate: quantitative research which utilises the language of positivism, and qualitative research which embraces a more reflexive, relativist voice.

The quantitative conversation has its roots firmly set in the natural sciences, inheriting a very coherent and powerful ‘voice’ with which to make its claims heard. Terms such as ‘objectivity’, ‘reliability’, ‘generalizability’ are so fundamental to the language of quantitative research that it can easily be overlooked that these are actually rhetorical devices, built upon and contained within a certain ontological framework (i.e. the conceptualisation of a specific knowledge domain). Though this framework provides a common basis for discussion and a vehicle for the advancement of ‘science’, it does, however, contain numerous assumptions about the nature of ‘knowledge’, about what is and is not able to be investigated, and about how this can be researched.

On the other hand, the qualitative conversation is much more disparate, with many different voices often speaking slightly different languages resulting in a less coherent ‘argument’ (McLeod, 2001c). Though there have been recent attempts at providing a more unified framework for qualitative researchers (Rennie, 2007b), the very nature of qualitative research, which is intrinsically ‘discovery-oriented’ and informed by different discursive traditions within our society, tends to work against any attempt to impose methodological certainties. As a result, qualitative research practice often adopts the concepts of pluralism and the notion of the researcher as a ‘bricoleur’ who brings together whatever different techniques are relevant to the achievement of their research goals.

5.2 Methodological pluralism

A number of authors have called for a pluralistic approach to investigating the intricacies and complexities of counselling and psychotherapy (Goldman, 1976; Gelso, 1979; Howard, 1983; Goss & Mearns, 1997; Slife & Gantt, 1999). Critiquing the tendency of researchers to rely on positivistic models derived from the physical sciences, Goldman (1976) called for a revolution in the methods used:

Tied to largely inappropriate models derived from the physical sciences, much of the research has been trivial, atomistic, and obsessed with statistics and technical matters of research design. Counseling researchers have often futilely pursued the goals of precision and control, despite the fact that the major objects of study - counselees and the counseling process - do not lend themselves to precise measurement, certainly not at this stage in the development of the behavioral sciences. Major changes in the methods and contents of research are needed. (Goldman, 1976 p.543)

Similarly, Howard (1983) believed that research in counselling and psychotherapy places too much emphasis on the discovery of nomothetic, causal laws similar to those in physics and other natural sciences. Instead, he called for a broadening of the ideas, procedures and concepts upon which researchers relied:

What I am suggesting is that a complete understanding of humans needs to consider a range of ontological perspectives, a variety of views of the nature of humans, and consequently it must employ a multiplicity of empirical research methods. I believe that a thorough understanding of humans will be facilitated by "methodological pluralism." (Howard, 1983 p.20)

A decade on, Goss and Mearns (1997) addressed the continuing divide between the competing paradigms of positivism/reductionism associated with quantitative methods, and the phenomenological/naturalistic approach of qualitative methods. Rather than continuing the 'paradigm war', the authors called for a pluralistic epistemology which acknowledged the unique contributions of each approach. Here the analogy of the complementary nature of wave and particle models of electrons is used – neither model has all the answers, but each adds to our understanding in different ways. Similarly, by utilising both positivistic and phenomenological ways of knowing, our understanding of therapy would be greater than relying on either approach on its own. The authors believed that a hermeneutic dialectic between the approaches would be more productive than competition or confrontation:

For the philosophies to work successfully together, it is necessary to establish a Husserlian hermeneutic dialectic between them. Husserl's phenomenology derived from a congenial dialectic, each party intending to contribute to the overall comprehension of the issue at hand. The desire for the illusory power of incontrovertible statements of apparent fact need not be entirely relinquished, but we must recognise the futility of attempting absolutist definitions of human experiencing, especially when trying to judge the efficacy of processes like

counselling and psychotherapy in which change and the fluidity of the organismic self is a necessary characteristic of its nature. (Goss & Mearns, 1997 p.195)

Recently, Hanson, Creswell, Plano Clark, Petska, and Creswell (2005) outlined the different ways that qualitative and quantitative methods could be integrated into mixed methods research in the field of counselling and psychology. Similar to Goss and Mearns (1997), they argue that the intentional use of different paradigms in a dialectical manner enables contradictory ideas and contested arguments to be honoured and constructively discussed rather than being reconciled or minimised. They go on to outline the steps involved in designing a mixed methods study, including deciding whether to use an explicit theoretical lens, identifying the data collection procedures, and identifying the data analysis and integration procedures. Here they construct a typology of different ways that methods can be combined, depending if methods are utilised sequentially or concurrently, whether the aim is explanatory, exploratory or transformative, and what priority is given to the different approaches (see Figure 5-1).

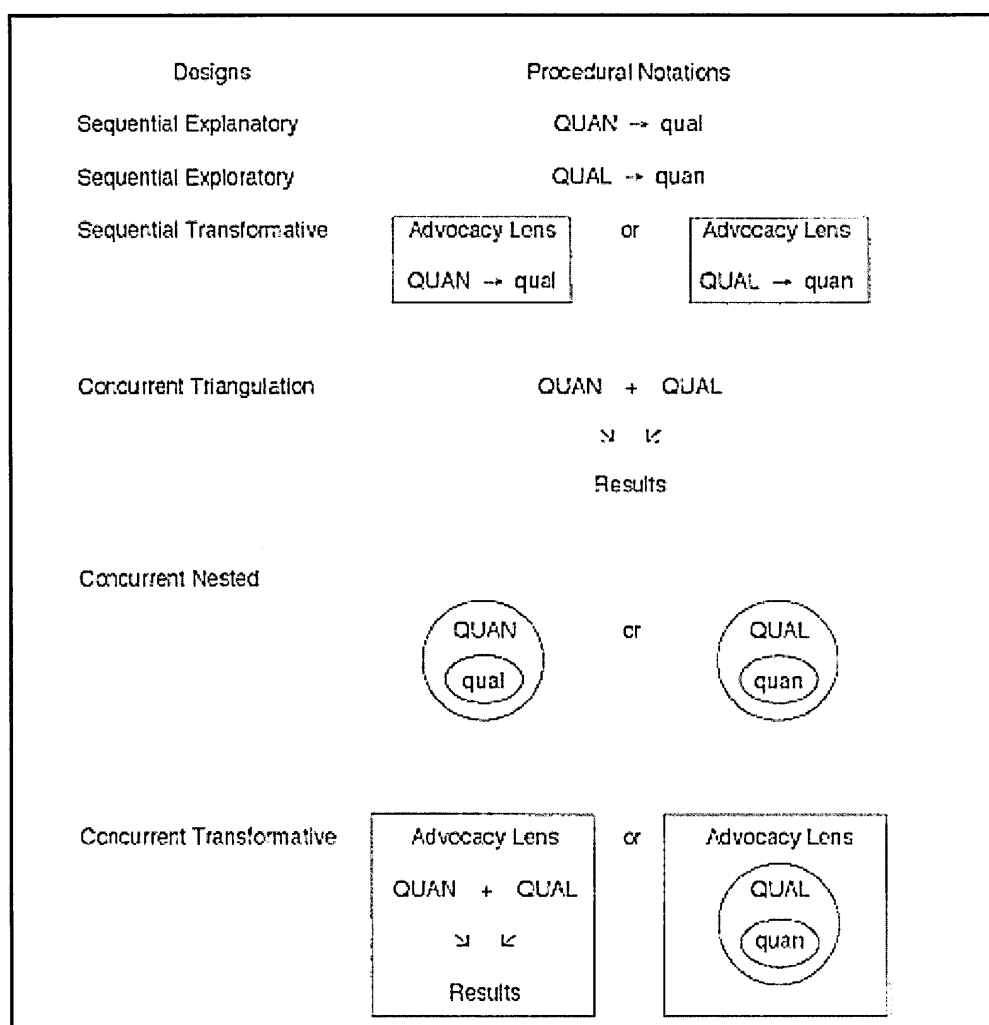


Figure 5-1 Typology for classifying mixed methods research designs (Hanson et al., 2005 p.228)

Using the above outline, the current study can be seen to fit within a developmental model which adopts a social constructionist ‘theoretical lens’. Here the intent of the quantitative data is to help inform and develop the qualitative data. Further, the study can be categorised as a ‘Concurrent Nested’ design with the quantitative and qualitative data being collected at the same time, but priority is given to the qualitative data (i.e. ‘quan + QUAL’). Though this model gives a good overall indication of the present study, it misses some of the finer nuances. For example, though the data was collected at the same time, the quantitative data was obtained first, then the qualitative data was partially obtained, then the quantitative data was analysed and the results used within the qualitative data collection phase. Further, as the study developed, the initial rationale for including the quantitative data changed such that the qualitative data began to inform the quantitative data. These subtleties demonstrate that a static model may fit as a presentation of what was initially intended, or what was implemented, but does not necessarily best describe the evolving nature of a mixed methods study ‘in practice’.

5.3 Research as bricolage

An alternative conceptualisation of mixed method studies in counselling and psychotherapy research as one of ‘bricolage’ is suggested by McLeod (1996; 1999; 2001c). Rather than presenting the methodological mix as a rigorously defined model, McLeod’s (1999) position is one where “qualitative and quantitative methodologies both represent useful ways of knowing, and that an adequate understanding of counselling requires both (in fact, involves using anything that comes to hand)” (p.118). Here McLeod points out the difference between how a method is implemented ‘in theory’ versus how it is actually conducted ‘in practice’. All approaches entail the adaptation and adoption of differing versions of a method which are considered appropriate to the circumstances of a particular study. Further, as the study progresses, methods are modified and altered to accommodate the knowledge and experience gained. Hence rather than a method being a ‘blueprint’ which must be adhered to without being deviated from, it can be seen more as a set of rough guidelines which act as a starting point from which the final ‘shape’ emerges over the duration of the study. This can be likened to a sculptor adapting his techniques and methods to ‘bring out’ the form in a block of stone, rather than imposing a prior image.

Additionally, researchers can be seen to adopt diverse methods which ‘work in practice’, rather than being limited to what should be done from any particular theoretical model. Instead of adhering to predefined principles of what is considered ‘appropriate’, researchers can be seen to borrow from a broad ‘toolkit’ of approaches, utilising various methods that others have documented, adapting them to their needs, and creating new approaches as required. Here the image of the researcher is not so much an ‘expert’ with a fixed, regimented way of doing things,

but more as a handyman who knows well the project he is working on, and adapts the method to fit this rather than trying to shape the project to fit the method.

McLeod's conceptualisation draws on that of Denzin and Lincoln (2000) who propose that the researcher may be seen as "a *bricoleur*, as a maker of quilts, or, as in filmmaking, a person who assembles images into montages" (p.4). With regard to the present study, the concept of a montage is particularly appropriate, where images are superimposed on one another to create a new picture, both containing the individual images, but constructing new meaning at the same time:

Montage invites viewers to construct interpretations that build on one another as the scene unfolds. These interpretations are built on associations based on the contrasting images that blend into one another. The underlying assumption of montage is that viewers perceive and interpret the shots in a "montage sequence not *sequentially*, or one at a time, but rather *simultaneously*" (Cook, 1981, p.172). The viewer puts the sequences together into a meaningful emotional whole, as if in a glance, all at once. (Denzin & Lincoln, 2000 p.5)

In the present study, contrasting images of therapy outcomes are obtained by using both qualitative and quantitative methods. A combination of numeric, linguistic and visual data are acquired which can be seen to provide different 'lenses' which shape our view of the outcomes of counselling and psychotherapy in different ways. An analogy here is that of different lenses on a camera, where a wide angle lens allows a broad but distorted view of the whole scene, while a zoom lens allows distant objects to be enlarged and brought into focus, and a macro lens allows very close objects to be captured in fine detail. Images from all the lenses may be from the same scene, but very different views are achieved. By combining these into a montage, a different view of the scene is obtained than from selecting one image alone.

Additionally, the study uses different approaches in the analysis and presentation of the results such that different 'layers' of the picture can be revealed. Here Wolcott's (1994) distinction between the description, analysis and interpretation of data is useful in terms of the interpretive intent of a study (McLeod, 1999). Different styles of research are seen to engage the data in different ways. For example, a phenomenological approach to a study may emphasise the careful description of an individual human experience. In comparison, thematic analysis such as grounded theory would focus on distilling the experience of a group of participants, looking to reveal the structure of the phenomenon being investigated. Meanwhile, hermeneutic research would attempt to develop an interpretive understanding of the data whereby knowledge and theory both inform and are informed by the interpretation process.

Within the present study, a rich descriptive account of one participant's experience is presented providing a unique, phenomenological account of one person's outcomes of counselling, as well as their experience of being part of the research itself. In contrast, a quantitative analysis of the questionnaire data adopts a more positivistic stance whereby participant's scores are aggregated to provide generalised results that can be compared to other studies and settings. A further layer of results is provided through a presentation of a montage of visual, linguistic and numeric data designed to reveal the variety and differences between participants. Finally, a thematic analysis is undertaken to construct a categorised understanding of participants' experiences. This whole endeavour can be seen to be part of a hermeneutic circle (Rennie, 2007a) whereby the researcher's previous experience and knowledge, in addition to previous theories, have shaped the interpretation of the data, as well as the data being used to construct new meaning and understanding of the outcomes of counselling and psychotherapy.

This approach offers a variety of angles in terms of data collection, analysis, and interpretation of results such that the final product is composed of a multiplicity of 'images'. Rather than attempting to present a 'true image' of some 'objective reality', this montage is intended as a 'dialogical text' inviting the reader to interact with it, to try out the different 'lenses' on offer in order to see how it changes their view (Denzin & Lincoln, 2000). Within this multiplicity, it is acknowledged that research is an interactive process shaped by the researcher's personal history, biography, gender, social class, race, ethnicity, as well as the various settings within which the research is conducted (Denzin & Lincoln, 2000). This includes the ethos of the counselling setting where the data was collected, the values of the researcher's supervisors and training institute, the prevailing 'politics' of both counselling and research, and the cultural norms and 'world views' of the society within which the study was undertaken. This is consistent with Bronfenbrenner's (1977b) conceptualisation of the ecological environment as a set of nested 'systems of influence' (the 'micro', the 'meso', the 'exo' and the 'macro') as discussed in the previous theory chapter. Here the research setting is seen as multi layered, with various influences acting both directly and indirectly to shape the study.

Extending from this, it is seen that research and science are not a neutral endeavour. As Denzin and Lincoln (2000) put it "The political *bricoleur* knows that science is power, for all research findings have political implications. There is no value-free science" (p.6). The present study can be seen as an attempt to influence current thinking in terms of how 'outcomes' are conceived and measured in the field of counselling and psychotherapy research. Rather than this being something which is simply achieved by handing clients a standardised questionnaire, the study is an attempt to get practitioners and researchers to reconsider the complexity of the task of finding out from people what 'comes out' of their therapy. This is aligned with contemporary calls for more diversity and creativity in terms of therapy outcome research (McLeod, 2001a; Rodgers, 2003; Slife, 2004).

5.4 A person-centred approach to research

In addition to conceptualising research as bricolage, the present study attempts to embrace an ethos compatible with the person-centred approach (Rogers, 1951a). In particular, the notion of psychotherapy research as a science of persons (Rogers, 1961) is adopted. From this perspective, science is not a detached and external body of knowledge, but rather something created by people, for people:

Science exists only in people. Each scientific project has its creative inception, its process, and its tentative conclusions, in a person or persons. Knowledge – even scientific knowledge – is that which is subjectively acceptable. Scientific knowledge can be communicated only to those who are subjectively ready to receive its communication. The utilization of science also occurs only through people who are in pursuit of values which have meaning for them. (Rogers, 1961. p.216)

Here Rogers is outlining a view of science not dissimilar to that presented by McLeod (1999) as discussed above, in terms of the actual practice and lived process of research being different from the theories and concepts. From this perspective, all research is inherently based upon “the immediate, subjective experience of a person. It springs from the inner, total organismic experiencing which is only partially and imperfectly communicable” (Rogers, 1961 p.222). Here scientific knowledge is seen as essentially subjective in nature, arising out of a desire to ‘know’, to construct conceptual order out of our experience. It is not inherently different from other forms of ‘knowing’, but rather is just another form of a person subjectively living their life. From this perspective, the methods adopted in a study are all subjective, lived choices dependent on the personal values and uniquely experienced history of the researcher. These choices include what is considered a ‘valid’ theoretical foundation, which setting is most appropriate, the approach to recruiting and interacting with participants, the form of analysis used, the manner of the communication and dissemination of results, and how the findings have an impact on practice. For Rogers, the aims of research were not dissimilar to the aims of person-centred therapy - to promote an openness to *all* experiencing, to permit *all* the sensings of ones intricate organism to be available to awareness including but not limited to the cognitive schemas associated with ‘scientific knowledge’.

Similarly, Mearns and McLeod (1984) suggest that the philosophy of the person-centred approach offers a set of ideas and values that can be equally applied to research as to therapeutic practice. They articulate a number of key features of this approach which are directly applicable to counselling and psychotherapy research:

1. The research participant is met as an equal. Rather than being a 'subject' of a study, participants are seen to be valuable contributors of equal importance as the researcher.
2. Emphasis on the frame of reference of the participants. A primary goal of research is to sensitively and accurately explore the frame of reference of the participant.
3. The process orientation of research. Both the people involved and research study itself are considered to always be in process, rather than static 'objects' of investigation or findings being presented as 'facts'.
4. The researcher seeks authenticity and aims to be as 'congruent' as possible, both with participants and to the situation of the research.
5. An acceptance of other value systems. The importance of the researcher maintaining a non-judgmental position and an unconditional acceptance and valuing of the other.

In terms of the present study, the intention has been to attempt to provide participants with a variety of methods which are useful and have meaning from their own frame of reference. Rather than assuming one or other method has superior validity or greater worth in terms of studying the outcomes of therapy, the aim was to construct a study such that participants themselves could utilise both methods and reflect on their experience. Within this, there is a core phenomenological epistemology and a belief in the validity and worth of an individual's experience. Participants are considered trustworthy informants and are the only truly valid source of data on their inner psychological processes.

A further implication of these person-centred principles is to draw attention to the personal involvement of the researcher in the inquiry process. This dimension of research has been widely discussed in recent years in terms 'reflexivity' (Finlay & Gough, 2003; Etherington, 2004), which refers to the importance of self-reflection around the research experience, by both researcher and participants. The present study was conducted in a manner that was highly mindful of the essential role of reflexivity, and included many opportunities for the researcher and participants to engage in dialogue around their experience of being involved in the investigation.

5.5 Reliability and validity of research

The above perspectives give a very different 'view' of what reliability and validity means in terms of research. Rather than attempt to be as objective as possible, free from error or other unwanted

disruptions to the measurement and analysis process, there is acknowledgement of the essentially ‘flawed’ nature of human enquiry. This creates a real difficulty in terms of constructing guidelines or principles for determining relative ‘quality’ of research. A number of authors have attempted to put into words some of the qualities which seem to reflect ‘good quality’ qualitative research within the field of counselling and psychotherapy, including Barbour and Barbour (2003), Fossey et al (2002), Morrow (2005), Parker(2004), Rennie (1995), and Stiles (1993; 1999).

<p>A. Publishability Guidelines Shared by Both Qualitative and Quantitative Approaches</p> <ol style="list-style-type: none">1. Explicit scientific context and purpose2. Appropriate methods3. Respect for participants4. Specification of methods5. Appropriate discussion6. Clarity of presentation7. Contribution to knowledge <p>B. Publishability Guidelines Especially Pertinent to Qualitative Research</p> <ol style="list-style-type: none">1. Owning one’s perspective2. Situating the sample3. Grounding in examples4. Providing credibility checks5. Coherence6. Accomplishing general vs. specific research tasks7. Resonating with readers

Table 5-1 Evolving Guidelines for Publication of Qualitative Research Studies in Psychology and Related Fields (Elliott, Fischer, & Rennie, 1999)

In particular, Elliott, Fischer and Rennie (1999) present a clear and concise set of guidelines which have become widely used for evaluating qualitative research studies. They present two sets of criteria, one for both quantitative and qualitative research, and another specifically for qualitative research (see Table 5-1 above). Following is a brief outline of the key points that the authors set out for each of the qualitative criteria.

1. Owning one’s perspective: Good qualitative research requires the researcher to be transparent about their theoretical orientations and personal anticipations. Researchers should have an awareness of how their values, interests and assumptions may affect their understanding of the phenomenon being investigated.
2. Situating the sample: Sufficient details of research participants should be provided such as gender, age, ethnicity, social class etc so that a potential reader can make an informed decision about how relevant any findings may be to them.
3. Grounding in examples: Sufficient quotations and samples of data should be provided such that

the conceptualisations and conclusions that a researcher makes can be checked out for possible alternative meanings and understandings.

4. Providing credibility checks: Relevant checks of categories, themes or accounts are undertaken including 'member checking' with the original participants, the use of multiple qualitative analysts, auditing of the analysis, comparing two or more varied qualitative perspectives, 'triangulation' with external factors or quantitative data.
5. Coherence: The results of the study are presented in a coherent and integrated fashion while maintaining the nuances of the data in the form of a data based narrative, a 'map', a framework, or other representation of the underlying structure of the phenomenon or domain.
6. Accomplishing general vs. specific research tasks: An appropriate method is used in terms of attaining either a general understanding (e.g. using a range of informants or situations) or a specific understanding (e.g. using a systematic and comprehensive single case analysis). Additionally, limitations of extending the findings to other contexts and informants are provided.
7. Resonating with readers: Material is presented in such a way that it 'fits' with others experiences, that it clarifies or expands prior understandings and is recognisable as an accurate representation of the subject matter.

The current study has utilised both the above criteria and features of the person-centred approach to research as defined by Mearns and McLeod (1984) as the guiding principles of the study.

5.6 Conclusion: constructing a methodological framework

The investigation that is described in the following chapters is primarily a qualitative study, based on narrative data collected from participants. However, the study also involved the collection and analysis of both visual and quantitative data. Moreover, the work required a substantial degree of critical analysis of the knowledge claims associated with existing mainstream methodologies and theoretical approaches within counselling and psychotherapy research, alongside disciplined attention to reflexive processes. The present chapter has attempted, within constraints of word length, to give an account of the underlying epistemological assumptions that have influenced the methodological choices made in the thesis. The following chapter describes how these methodological choices were implemented in practice.

6 METHOD

6.1 Setting

The study was conducted in a ‘real world’ clinical setting, with participants recruited from the general public. The researcher had a good working relationship with the centre, having previously been a counsellor there. This facilitated the research project being integrated into the day to day running of the counselling centre with as little disruption as possible.

6.1.1 *Counselling centre*

The “Tom Allan Centre” counselling service in Glasgow was established in the mid 1980s under the umbrella of the Church of Scotland, though counselling is provided to the general public on a non-denominational basis. The centre is managed by Cross Reach, the social care arm of the Church of Scotland. It is an organisational member of COSCA (the professional body for counselling and psychotherapy in Scotland), an accredited service by BACP (the British Association for Counselling and Psychotherapy), and a registered charity in Scotland.

The centre runs on a voluntary basis, with counsellors and reception staff giving their time free of charge. In addition to volunteers, the service has a full time paid manager and deputy manager, as well as a full time office administrator. Principal funding is provided by Cross Reach, supplemented by various other activities such as counselling skills training, along with donations from people who attend the service.

6.1.2 *Counselling rooms*

The centre is equipped with 9 dedicated counselling rooms of various sizes. Each room has at least two comfortable chairs, with the majority having three or more chairs. Large cushions are also provided in some rooms. Each room contains a side table on which various literature is made available about the counselling centre, as well as paper and writing implements. Lighting is provided by overhead fluorescent tubes, with the option of using floor standing bulb lights as an alternative. Though not explicitly sound proofed, the counselling rooms do provide a good level of privacy, and are situated such that they are separated from the administrative and staff rooms.

6.1.3 *Counsellors*

At the time of the study, counselling at the centre was provided by approximately 60 volunteer counsellors from a variety of orientations including Psychodynamic, Person-centred, Gestalt, Transactional Analysis and Integrative approaches. The experience of counsellors varied from fully accredited practitioners to counselling diploma trainees. Each counsellor typically saw between 1 to 5 clients per week, usually for 50 to 60 minutes each. All counsellors received regular

group supervision at the centre to discuss any client issues that may have arisen, and to keep their supervisors informed of their general case load. Supervisors met regularly with the service managers to review the overall case load of the centre and to discuss any specific issues that may have arisen.

6.1.4 Service users

Service users of the centre came from the greater Glasgow area and were all self-referred. The centre catered for adults seeking either one to one counselling or couples counselling. Presenting problems included depression (25%), anxiety and stress (20%), marital and family problems (19%), relationship issues (14%), bereavement (7%), anger management (4%), sexual abuse (3%), alcohol and drug dependency (3%), eating disorders (1%), low self esteem (1%) and other personal/emotional difficulties. The age of people who attended the centre varied significantly from 16 through to 90, with an average of around 38 years. Approximately 58% of these people are female, 42% male.

6.1.5 Referral

Each person who contacted the centre for the first time was processed through a referral system onto an initial waiting list of approximately 2 to 3 months for a half hour intake assessment interview. At the interview, a trained counsellor took details of a person's background and presenting problem, and provided information about the service. After the intake interview, people were placed on a further waiting list for the next available counsellor, usually for between 1 to 10 weeks.

6.1.6 Attendance

Approximately 1000 people contacted the centre enquiring about counselling each year. Of these, between 30% and 40% went on to see a counsellor on a regular weekly basis, meaning that between 300 and 400 new clients were typically seen each year. The number of sessions attended varied significantly from just one session through to hundreds of sessions spanning multiple years. Additionally, around 10% of clients returned to the centre for further counselling at a later date, some for three or four distinct 'episodes' of therapy. On average, however, people attended a single episode of around 12 sessions of counselling, with most (80%) attending fewer than 20 sessions and almost all (95%) completing their counselling within 40 sessions.

6.2 Participants

All participants were recruited from people who attended an intake assessment interview at the Tom Allan counselling centre from May 2005 through to August 2006.

6.2.1 Recruitment of participants

Counsellors at the centre were informed that a study was taking place through a brief 30 minute presentation of the proposed research. Around 20 counsellors attended the presentation which outlined the general background of the study, and informed them of what would be involved for any participants. Additionally, an information sheet (see Appendix A) was distributed to all counsellors requesting their assistance in recruiting participants. A project information sheet (see Appendix B) and contact consent form (see Appendix C) were made available in the reception area for potential participants to read. Receptionists were requested to draw attention to this material when people arrived for their initial intake assessment interview. Counsellors doing a pre-counselling intake assessment interview were also asked to draw people's attention to the research, and to hand any completed contact consent forms in to the office.

Over the 15 month recruitment period, 585 people attended an intake interview at the centre, of which 78 people consented to be contacted for the study. This proportion reflects the difficulty of recruiting participants in a busy volunteer-run service. Some volunteer receptionists were more aware of the project than others, resulting in inconsistencies regarding new clients being informed of the research project. Similarly, volunteer counsellors doing the initial intake assessment interview varied in the priority they gave to the research, sometimes seeing the project information sheet as being just too much additional information for clients to take in and so omitting this from the interview all together. Further, there were times when the supply of information sheets and contact consent forms simply ran out, and were not replaced until the researcher next visited the centre.

6.2.2 Pre-counselling participants

After receiving a contact consent form from potential participants, the researcher attempted to contact each person to arrange a pre-counselling interview at a date and time convenient to the participant. Of the 78 people who gave their consent to be contacted, 13 had already started counselling by the time the researcher was able to contact them, 11 could not be contacted by the researcher, 8 withdrew from the study after discussion with the researcher, and 3 failed to attend the arranged pre-counselling interview.

This left 43 people who attended a pre-counselling interview with the researcher. Of these participants, 25 (58%) were female, 18 (42%) were male, with ages ranging from 18 through to 66, mean 40.75. All participants were of white (British/European) ethnic origin with a mixture of employment statuses including skilled (14), semi-skilled (9), professional (7), unemployed (6), retired (3), student (2) and housewife (2). Presenting problems were classified as depression (14), anxiety/stress (9), anger management (6), relationship or family problems (5), bereavement (3), dependency (1), and unspecified emotional/personal problems (5). For all but two of the participants, this was their first use of the counselling centre.

6.2.3 Post-counselling participants

Of the 43 participants who attended the pre-counselling interview, 7 did not receive any counselling, 8 withdrew from the study after completing their counselling, 6 could not be contacted by the researcher on completion of their counselling, and 3 failed to attend the arranged post-counselling interview. A further 2 participants had not finished their counselling by the end of the data collection phase of the research project and were withdrawn from the study. Participants reasons for withdrawing from the study included attending counselling elsewhere (1), intending to resume counselling shortly (1), moved to a different city (1), too busy to participate (1), feeling a lot better and not wanting to 'rake it all up again' (1), that counselling didn't work and feeling too vulnerable to participate (1), and that counselling ended prematurely so didn't see the point in participating (1). One person did not give a reason for their withdrawal.

This left 17 participants who were interviewed by the researcher at both pre and post-counselling. Of these participants, 9 (53%) were female, 8 (47%) male, with ages ranging from 24 through to 66, mean 43.36. Presenting problems for this group consisted of depression (5), anger management (4), relationship and family problems (3), anxiety/stress (1), bereavement (1), dependency (1), and unspecified emotional/personal problems (2). The number of sessions attended ranged from 1 through to 33 with a mean of 16.25. This was slightly higher than the typical mean for the service of 12 sessions, likely due to the fact that a number of participants who withdrew from the study had not attended many sessions.

6.2.4 Follow-up participants

Of the 17 participants who attended a post-counselling interview, 9 also returned for a follow-up interview, of which 5 (56%) were male and 4 (44%) female. Of the 8 participants who did not complete the follow-up stage, 2 could not be contacted after this period, 1 did not want to do a follow-up interview, 1 did not attend the arranged interview, and a further 4 finished their counselling too late to be included in the follow-up data collection phase of the study.

6.3 Instruments

The study used a combination of a traditional quantitative outcome questionnaire (the CORE-OM) along with a visual method for collecting data on the outcomes of counselling (the LSM). Additionally, qualitative interviews were used to explore the participant's experiences and reflections on using the different methods.

6.3.1 CORE-OM Questionnaire

The CORE-OM (Clinical Outcomes in Routine Evaluation – Outcome Measure) (see Appendix G) questionnaire is a two page, 34 item standardised outcome measure widely used both in clinical

practice and in research to obtain data on various elements of a client's distress (see Section 2.1.4 in the literature review for further details on the background and use of the CORE-OM questionnaire).

6.3.1.1 Item description

The measure asks respondents to rate themselves over the last week on items for subjective well-being (4 items), commonly experienced problems or symptoms (12 items), life/social functioning (12 items), and risk to self and to others (6 items). The 12 items for problems and symptoms are further divided into clusters to address anxiety (4 items), depression (4 items), physical problems (2 items) and trauma (2 items). Similarly, the 12 life/social functioning items are divided into clusters to address general functioning (4 items), close relationships (4 items) and social relationships (4 items). Half of the items focus on low-intensity problems (e.g. 'I felt tense, anxious or nervous') and half focus on high-intensity problems (e.g. 'I have felt panic or terror') (CORE System Group, 1998).

6.3.1.2 Domains

The four domains of Wellbeing, Problems, Functioning and Risk are designed to have theoretical significance. In particular, the first three domains are derived from the phase model of change proposed by Howard, Lueger, Maling, & Martinovich (1993). Here it is conceptualised that there should be progressive improvement through different phases beginning with increased subjective wellbeing, followed by reduction of problems and symptoms, and finally improved ability to function in life. The six risk items which cover suicidal ideation and harm to self and others are intended as clinical indicators of respondents being 'at risk' to themselves or others (CORE System Group, 1998).

6.3.1.3 Rating and scoring

Respondents are asked to rate each item using a 5 point Likert scale: 'Not at all', 'Only Occasionally', 'Sometimes', 'Often', and 'Most or all the time'. The majority of items are phrased such that a response of 'Not at all' equates to 0 while 'Most or all the time' equates to 4, however eight items are phrased positively (e.g. 'I have achieved the things I wanted to') where 'Not at all' equates to 4 and 'Most or all the time' equates to 0. This creates a problem based scoring system such that the higher the value, the more problems the individual is reporting, or the more distressed they are (CORE System Group, 1998).

Historically, scoring is achieved by adding all completed item ratings together then dividing by the number of completed items. Additionally, mean dimension scores are calculated by totalling all Wellbeing, Problem, Functioning and Risk items and then dividing by the respective number of completed items. An 'All minus Risk' score is also calculated by adding together all non risk items then dividing by the number of completed non-risk items. This system produces 6 scores each with

a value between 0 and 4, one for each of the domains and two aggregate scores for ‘All’, and ‘All minus R’ (CORE System Group, 1998).

Non-clinical range				Clinical range							
Total score	Clinical Score	Simple score	Severity Level	Mild, Moderate, Moderate-to-severe				Severe			
				Total score	Clinical Score	Simple score	Severity Level	Total score	Clinical Score	Simple score	Severity Level
1	0.3	0	Healthy	Clinical cut-off level				85	25.0	25	Severe level
2	0.6			34	10.0	10	Mild level	86	25.3		
3	0.9			35	10.3			87	25.6		
4	1.2	36		10.6	88			25.9			
5	1.5	37		10.9	11	89		26.2	26		
6	1.8	38		11.2		90		26.5			
7	2.1	39		11.5		91		26.8			
8	2.4	40		11.8	12	92		27.1	27		
9	2.6	41		12.1		93		27.4			
10	2.9	42		12.4		94		27.6			
11	3.2	43		12.6	13	95		27.9	28		
12	3.5	44		12.9		96		28.2			
13	3.8	45		13.2		97		28.5			
14	4.1	46		13.5	14	98		28.8	29		
15	4.4	47		13.8		99		29.1			
16	4.7	48		14.1		100		29.4			
17	5.0	49		14.4	15	101	29.7	30			
18	5.3	50		14.7		102	30.0				
19	5.6	51		15.0		103	30.3				
20	5.9	52		15.3	16	104	30.6	31			
21	6.2	53		15.6		105	30.9				
22	6.5	54	15.9	106		31.2					
23	6.8	55	16.2	17	107	31.5	32				
24	7.1	56	16.5		108	31.8					
25	7.4	57	16.8		109	32.1					
26	7.6	58	17.1	18	110	32.4	33				
27	7.9	59	17.4		111	32.6					
28	8.2	60	17.6		112	32.9					
29	8.5	61	17.9	19	113	33.2	34				
30	8.8	62	18.2		114	33.5					
31	9.1	63	18.5		115	33.8					
32	9.4	64	18.8	20	116	34.1	35				
33	9.7	65	19.1		117	34.4					
<div>Guidance notes</div> <div>1. The original mean item score can be readily calculated by dividing the clinical score by 10.</div> <div>2. The 'simple' score uses the first integer only of the clinical score as a rough guide.</div> <div>3. The reliable change index is 5 points and the cut-off level is a clinical score of 10 (or .5 and 1 respectively if using the traditional scoring method).</div>					66	19.4		21	Moderate-to-severe level	118	
				67	19.7	119	35.0				
				68	20.0	22	120			35.3	
				69	20.3		121	35.6			
				70	20.6		122	35.9			
				71	20.9	23	123	36.2		38	
				72	21.2		124	36.5			
				73	21.5		125	36.8			
				74	21.8	24	126	37.1		39	
				75	22.1		127	37.4			
				76	22.4		128	37.6			
				77	22.6	25	129	37.9		40	
				78	22.9		130	38.2			
				79	23.2		131	38.5			
				80	23.5	26	132	38.8		41	
				81	23.8		133	39.1			
				82	24.1		134	39.4			
				83	24.4	27	135	39.7	42		
				84	24.7		136	40.0			
				85	25.0		137	40.3			

Table 6-1 CORE-OM scores and severity levels (Barkham et al., 2006 p.8)

Recently, a new scoring system has been introduced which adapts the previous method to produce ‘clinical scores’ from 0 to 40 by multiplying the above mean score by 10 (Barkham et al., 2006). This approach makes it possible to assign meaning to whole numbers rather than to fractions of scores, and has led to the adoption of severity level indicators as presented in the table below.

Using the new clinical scores, results from 0 to 5 indicate 'healthy', 6 to 9 as 'low level', 10 to 14 are 'mild level', 15 to 19 as 'moderate level', 20 to 24 as 'moderate to severe level', and 25 to 40 as 'severe level' (see Table 6-1).

6.3.1.4 Reliability and validity

The reliability of a questionnaire refers to its consistency, in particular to how consistently items relate to each other, to consistency between different parts, and to consistency of participant's responses over time (Kazdin, 2003). Initial analysis demonstrated that the CORE-OM has adequate internal reliability and test-retest stability with a test sample of both clinical respondents (n=890) and non-clinical respondents (n=1106) (Evans et al., 2002). Using Cronbach's coefficient α to assess the amount of covariance between all items resulted in a value of 0.94 for both clinical and non-clinical populations, indicating an appropriate internal reliability. Test-retest reliability was calculated with a sample of 43 non-clinical students using Spearman's ρ resulting in a value for all items of 0.90 demonstrating good stability over time.

Validity refers to whether a questionnaire actually measures what it intends to (Kazdin, 2003). The CORE-OM has shown good convergent validity with conceptually similar questionnaires such as the SCL-90 and BDI (see Part 1 of the literature review for details of these measures) indicating that it is a valid measure for general psychological distress. However, recent analysis has revealed a poor fit when attempting to validate the domains of wellbeing, problems, and functioning (Lyne et al., 2006). There appears to be a high level of co-variance between items with most variance explained by the wording of items as being either positive or negative. As such, there is no empirical evidence to support the phase model conceptualisation for the CORE-OM domains. However, there is good evidence that when scoring all 28 non-risk items as one scale, and the 6 risk items as a separate scale, the CORE-OM is psychometrically valid and reliable.

6.3.1.5 Reliable and clinically significant change indicators

In order to be utilised as an individual outcome measure, a questionnaire must be able to indicate change for a single participant. Jacobson and Truax (1991) have proposed an approach which requires this change to be both statistically reliable and clinically significant. Specifically, they specify that for a measured change to be statistically reliable, there must be a 95% probability that it was not due to measurement error, or to chance alone. For clinically significant change to occur, the measured score must demonstrate a shift from a score more representative of a clinical population, to one that is more representative of a non-clinical population.

Initial data for the CORE-OM to calculate reliable and clinically significant change provided clinical cut-off points for each domain, separated for male and female (see Table 6-2 below). Recent analysis of a more representative sample has provided more conservative cut-off data (Connell et al., 2007). Using the new 'clinical score' (see Table 6-1 above), Connell et al calculated

an overall cut-off score for men of 9.3 and 10.2 for women, and recommended a rounded value of 10 for all respondents (equivalent to a mean value of 1.0). A reliable change index was calculated for the general population to be 3.6, and for the clinical sample to be 5.9, with Barkham et al (2006) recommending a value of 5 being used when calculating statistically reliable change.

Domain	Male	Female
Well-being	1.37	1.77
Problems	1.44	1.62
Functioning	1.29	1.30
Risk	0.43	0.31
All non-risk items	1.36	1.50
All items	1.19	1.29

Table 6-2 CORE-OM clinical cut-off scores (CORE System Group, 1998)

6.3.1.6 Questionnaire completion

The questionnaire usually takes between 5 to 10 minutes to complete by the participant. For this study, participants were encouraged to raise any questions they had regarding any aspects of completing the questionnaire, or to seek clarification on any items. This meant that at times the questionnaire took slightly longer to complete than usual (between 5 and 15 minutes). The questionnaire took a further 2 to 3 minutes to be rated by the interviewer using a hand held computer to simplify calculations.

6.3.1.7 Results graph

To aid participant’s interpretation of the results, a graph of mean dimension scores for Wellbeing, Problems, Functioning and Overall (All) was used (see Figure 6-1).

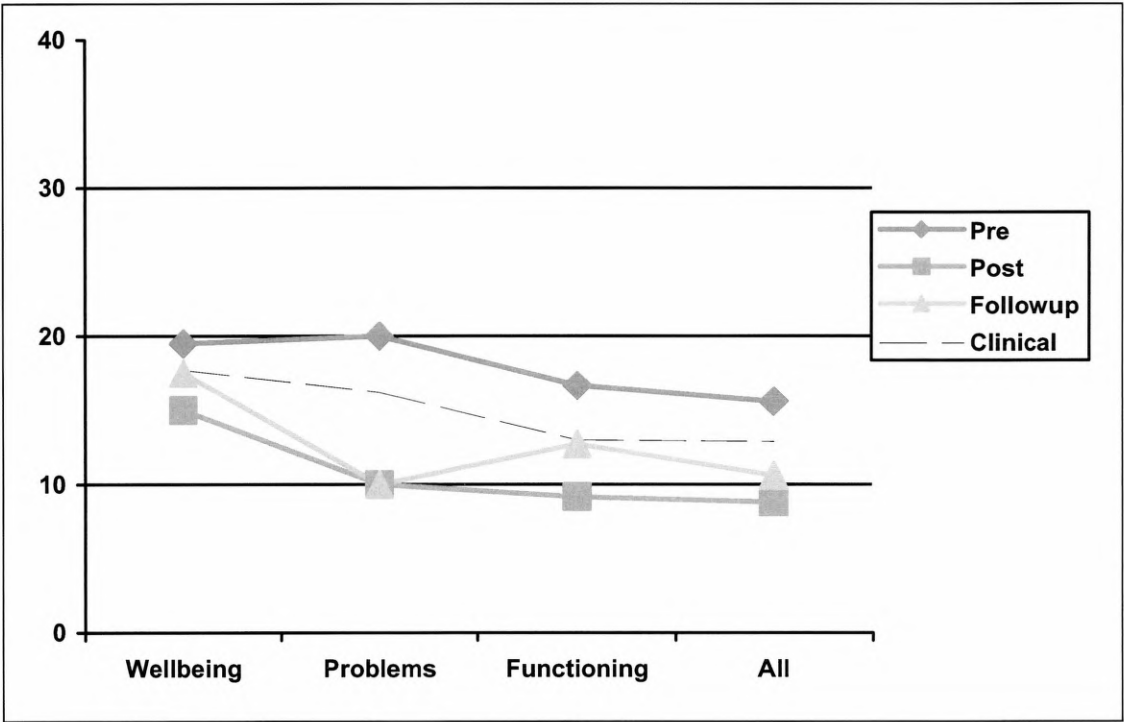


Figure 6-1 Example of a CORE-OM results graph

Scores were plotted for pre-therapy, post-therapy, and follow-up, along with the original published clinical cut off scores for male or female, depending on the gender of the participant. The orientation of the graph was chosen to ease interpretation of 'shifts' either 'up' or 'down' in the scores, and to allow all the information to be presented on a single graph rather than separately by dimension. This structure also facilitated the plotting of data by hand during the interview. The example graph clearly shows a drop in all dimensions from pre-therapy to post-therapy. Further, this shift demonstrates a clinically significant change as all scores have dropped below the clinical cut off line. This change is maintained, though slightly deteriorated at follow-up.

6.3.2 Life Space Map (LSM)

The Life Space Map is a free form diagrammatic device designed to facilitate participants to record their perceptions of their life space at a given moment in time. It is primarily based on Kurt Lewin's (1936) principle of the life-space along with Vance Peavy's (1997; 2004) work on sociodynamic counselling (see the theory chapter for a fuller discussion of the implications of these other authors' work for the present study). In particular, the approach taken draws directly on the method proposed by Peavy (2008b) for using Life Space Mapping as a therapeutic and learning tool.

6.3.2.1 Mapping instructions

The mapping instructions (see Appendix F) introduced participants to the concept of the 'Life Space' and the mapping process. Rather than being an explicit step by step guide, the instructions were designed to be a series of prompts and suggestions for participants to 'map out' the most significant things in their life at that time from their own perspective and in their own way. Suggestions of things to include were friends, family, partner, work colleagues etc, places such as home, university, school, work, the outdoors, etc, sporting activities, cultural activities, social engagements, religion, politics etc.

The instructions also drew attention to anything that the participant may have been experiencing difficulty with, in particular any areas of tension or conflict. Participants were asked to identify, if possible, what caused the tension, whether there were conflicting needs or demands, or if things pulled them in different directions. The instructions also asked participants to reflect on what kept the situation like it was, and where the important boundaries were, where one thing or area came up against another one. Participants were also asked to try to indicate where they felt their life was heading, whether they thought they were moving towards or away from certain things, or being pushed or pulled in different directions.

6.3.2.2 Drawing materials

A variety of simple drawing materials were made available for participants to use. Various colours and types of pens, pencils and crayons were first tested by the researcher to ensure that they could

be adequately digitally scanned afterwards. To this end, several light colours were excluded such as white crayons, or light yellow pencils. It was found that good quality, fine point felt tip pens, and bold marker pens provided the best drawings for scanning, and benefited from not breaking or snapping. However, in order to provide participants with a variety of options, a number of darker coloured pencils and crayons were also made available.

A choice of paper sizes was provided including A1 (841mm x 594mm) , A2 (594mm x 420mm) and A3 (420mm x 297mm), with the stipulation that more than one sheet could be used as required. This selection of paper was obtained by using a standard A1 flip chart pad, then dividing this in half to provide A2 sized paper, then half again to provide A3 size. A2 and A3 sized sheets proved to be most workable as they were small enough to fit on the side tables that were available in each interview room, whereas the use of A1 sheets required the participant to work on the floor.

6.3.2.3 Life Space Map interview

The life space map typically took between 15 and 60 minutes to complete. Participants were encouraged to use whatever form or content they felt most meaningful to themselves, and were reminded that the aim was to create something that worked for them, rather than being a ‘good’ picture. To this end, no restrictions were placed on the style, structure, scope or time of the mapping process apart from the inherent limitations of the drawing material provided.

To start with, it was suggested that participants may want to choose one thing that was significant in their life just then and to put this down on the paper first. Participants were then encouraged to start adding other things to this one by one, and to show how each thing connected with what was already there. Participants were free to ask any questions as they went, and to discuss with the researcher what they were doing. Care was required here not to engage in ‘therapy’ with the participant but rather to support them in constructing as full a picture of their life as they felt capable of. As a participant spoke about things in their life, the researcher would encourage them to find a way of representing this on their map. For example, “How could you show that on your map?”, “Is there a way of drawing that somehow?”, or “How would you describe that in the drawing”.

Inhibitions around the drawing process and difficulties about being presented with a ‘blank canvas’ were discussed and worked with. To assist with this, anonymised versions of a variety of different styles of maps were available for participants to view if they got ‘stuck’ with where to begin (see, for example, Figure 6-2 below). On completion, participants were asked to take some time to consider whether they felt their map was an accurate representation of their life space and if there was anything they would change in the map which would help them in the future to recall their current situation.

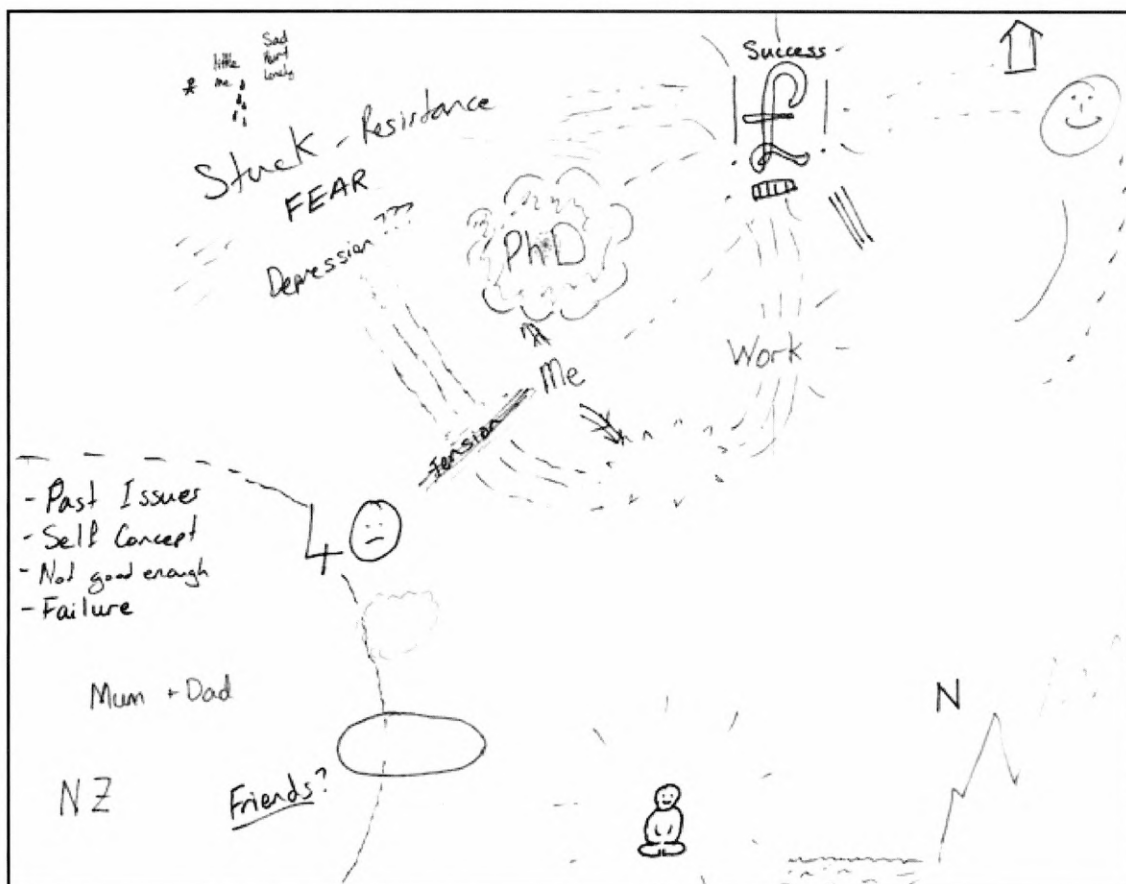


Figure 6-2 Example of an anonymised sample Life Space Map

6.3.3 In-depth qualitative interviews

In depth qualitative interviews were used as a method to engage with and explore the participant's phenomenological experience in relation to the study. Open questions were designed to facilitate participants' reflection on the changes they perceived at the different stages in their involvement. Additionally, questions were asked about how helpful the different methods were in terms of enabling participants to discern change from their own frame of reference. Further questions were asked about people's experience of being part of the study.

Rather than a rigid set of questions, interview schedules were only used as a general guide to keep a focus on the research topic. Questions were asked in a tentative, enquiring manner, with the interviewer reflecting back their understanding of what the participant has said and seeking clarification on points of interest. This process was designed to aid engagement and clarification, with the aim of tapping into participants' rich narrative. Here, the researcher - participant interaction was not seen simply in the form of 'question and answer', but rather a complex co-influencing dialogue. It can be seen that the researcher's questions and observations acted to stimulate further reflection, but also directed and focused the participant towards a specific research aim. In addition, there was also a containing element to the researcher's statements which were aimed to keep the interview on track.

6.3.3.1 Reflection on change using CORE-OM and LSM

Participants were asked to reflect on the changes they saw after being shown their previous Life Space Map(s) and then their previous CORE-OM questionnaire(s) plus results graph. Questions were designed to explore the participants' perception of change from their own frame of reference, and to discover what they felt had allowed the changes to occur, including the role of counselling, if any.

Typical questions included:

- What do you see has changed from looking at your previous CORE-OM / LSM?
- What strikes you most / stands out most / surprises you most?
- How do you feel seeing the difference from then until now?
- What do you feel allowed the change to occur?
- What part, if any, did the counselling play in this change?
- What was the most significant thing that counselling contributed?
- What did you get from counselling that you didn't get from anywhere else?
- How would you describe the value of counselling, for example, if you were asked by a friend?

6.3.3.2 The experience of using CORE-OM and LSM

Participants were asked about their experience using the Life Space Map and the CORE-OM questionnaire plus results graph, and the usefulness of each method for reflecting on change. At the end of the interview, participants were also asked about their experience of being part of the research project. The aim of these questions was to explore the participants' experiences of using the different methods, and to discover how they made use of them over the duration of the study.

Typical questions included:

- How did you find completing the CORE-OM questionnaire / Life Space Map?
- What did you find valuable / difficult / problematic? Why?
- How useful was the CORE-OM / LSM for seeing any change?
- Which method did you find easier/more difficult/more useful/more accurate? Why?
- How did you find being part of the research project?
- Do you feel being part of the study influenced your counselling?
- Have you got anything out of being part of study?

6.3.4 Electronic instruments

To facilitate analysis via computer, the interviews, Life Space Maps, and CORE-OM questionnaire data were captured and stored electronically. Digital audio recordings were made during the actual

interviews to improve sound quality rather than being converted afterwards from standard audio tape. Life Space Maps were completed on paper during the interview then digitally scanned at a later date. Similarly, CORE-OM forms were completed on paper during the interview. However, this CORE-OM data was then entered by the researcher into a computer during the actual interview at the post-counselling and follow-up stage so that participants could reflect on the changes indicated by the questionnaire scores.

6.3.4.1 Digital audio recording

A variety of audio recording devices were tested and trialled in order to obtain high quality recordings of the interviews. Both standard analogue tape and digital audio discs (MiniDisc) were tried before settling on a high quality hard disk based MP3 recorder. All interviews were recorded using an external microphone to achieve clearer sound quality. It was found through experimentation that using two individual 'lapel' microphones produced superior results to a single boundary microphone. For initial pre-counselling interviews, however, a single microphone was still used to lessen the intrusion of the recording equipment. For both post-counselling and follow-up interviews, participants were asked at the beginning of each interview to clip a small microphone onto their lapel.

Interviews were recorded using a digital compression system called MPEG Audio Layer 3, more commonly referred to as MP3. The lower quality pre-counselling interviews were recorded at 128K bps (bits per second), while the rest of the interviews were recorded using 192K bps. This level of compression provided extremely clear recordings for voice, given that 128K bps is commonly used for music downloads on the internet, while 192K bps is considered near CD quality. The MP3 compression format allowed the recordings to be easily transferred to the researcher's computer system and accessed from within the analysis software without any loss of quality through transcoding (changing from one format to another, such as from analogue tape to digital, or from the MiniDisc to MP3). This meant that the researcher was able to work directly with the participants' spoken word as originally captured in the interviews.

6.3.4.2 Digital image capture

The Life Space Maps were digitally transferred to computer using a large flatbed A3 scanner. Though not ideal as this system required larger A2 and A1 maps to be scanned in sections then digitally amalgamated, this method provided superior colour resolution and less image distortion than from digitally photographing each map. Larger A1 or A2 scanners would have been preferable but were not available to be used in a confidential manner (the researcher would have had to leave the maps unattended with a third party). Images were scanned using 24bit colour at a resolution of 300 by 300 dpi (dots per inch) to produce high quality JPEG images which could be accessed directly from within the analysis software.

6.3.4.3 CORE-OM data entry and graphing

Individual CORE-OM item scores were entered directly into a hand held computer spreadsheet during the interview session at the post-counselling and follow-up stage of the research. This allowed the calculation of the mean dimension scores (Wellbeing, Problems, Functioning and Risk) along with the two global scores ('All' and 'All minus Risk') to be achieved quickly and efficiently 'on the spot' and the results graphed for the participant to see and compare with their previous data. This data was then transferred to the researcher's main computer so that it could be available for a more detailed statistical analysis.

6.3.4.4 Secure data backup

To ensure the safety of recorded material, it was important to maintain multiple 'backups' of the data on different physical devices. A single storage device such as a hard disk may become corrupt causing all digital data to become unusable. This was particularly problematic with regard to the digital audio recordings as there was no analogue backup as would be the case with using standard audio tape. To this end, the researcher maintained a copy of the data on multiple hard drives, such that if any one failed, a copy could be retrieved from any of the others. The researcher's main computer utilised a 'RAID 1' hard disk configuration such that all data was simultaneously 'mirrored' on two identical disk drives. In addition, data was synchronised with the researcher's laptop to ensure further backup. Finally, a copy of the data was stored on an external USB hard drive which could be stored away from the main computer system to safeguard against physical loss or destruction of the computer.

To ensure confidentiality, it was important that all these hard disk backups were sufficiently encrypted. The researcher's main computer and laptop used Microsoft's 'Encrypted File System' (EFS) which is standard with Windows XP Professional. This allowed the primary data storage to be simply encrypted such that it could only be accessed via the researcher's login. The external backup device utilised a software package called "TrueCrypt", an open licence, military strength encryption system which again ensured that only the researcher had access to this material.

6.4 Procedures

6.4.1 Pre-counselling

Pre-counselling interviews were conducted with participants some time between their initial intake assessment interview at which they gave their consent to be contacted, and their first counselling session. The time between the pre-counselling interview and the beginning of counselling was quite variable, ranging from 1 to 12 weeks, as this depended on waiting list times at the centre and the ability of the researcher to contact potential participants. Interviews were conducted at the counselling centre and lasted for between 20 and 80 minutes with most (80%) taking less than an

hour. Each participant was assigned a unique numerical code which was used throughout the study to keep track of their interview recordings, CORE-OM questionnaire and Life Space Maps.

6.4.1.1 Introduction and initial consent

At the start of the interview, participants were given the project information sheet (see Appendix B) to re familiarise themselves with the study, and asked if they had any questions, or wanted anything clarified. At this stage it was re-emphasised that participation in the study was entirely voluntary, and that the content of the interview would not be shared with the participant's counsellor at any stage during the research project.

Following this, participants were asked to sign an initial participation consent form (see Appendix D) which outlined the key points regarding their involvement with the study. It was explained to participants that they would have a further opportunity at the post-counselling and follow-up stages to give specific consent for the use of the material gathered during the interviews. The intent here was to provide a process of consent whereby participants were given multiple opportunities to evaluate their involvement in the research project from a more informed perspective.

6.4.1.2 Pre-counselling CORE-OM

Participants were then handed the CORE-OM questionnaire (see Section 6.3.1) and asked to read and complete this with respect to how they had been over the last week. Participants were encouraged to ask any questions or seek clarification on any items, and informed that they could leave any item blank if they so desired.

The questionnaire was consistently given at the beginning of each interview in order to replicate its use in clinical practice, where clients are usually asked to complete the questionnaire before their counselling session begins. The intent here was for participants not to be influenced by first doing the Life Space Mapping task, so that the results would be as comparable as possible to the large body of clinical data already gathered by the CORE systems group.

6.4.1.3 Pre-counselling LSM

Following the CORE-OM questionnaire, participants were given the LSM instruction sheet (see Appendix F), and asked to map out the significant things in their life at that moment as detailed in section 6.3.2. This was an interactive process with the participant encouraged to ask any questions about the drawing process and to talk about what they were doing if they desired. This process was audio recorded for future reference to aid comprehension of the LSM by the researcher.

Particular care was taken here as it was acknowledged by the researcher that this could be a challenging task for participants to undertake before the beginning of their counselling. Care was

taken to not ‘open up’ things for participants, and to keep the focus on the mapping task rather than engaging with any underlying issues or problems.

6.4.1.4 Debriefing

Once the LSM was completed and the participant had finished discussing any of the content they desired, the researcher brought a focus to the participant’s experience of using the two outcome measures, and how they felt about being part of the research so far. Care was taken here to check out how they were feeling after the potentially exposing process of completing the LSM. Participants were reminded that further support was available from a trained counsellor if required. Finally, participants were asked if they had any suggestions on whether any aspects of the study could be improved from their perspective, especially with regard to any of the written material. This whole process was audio recorded to enable later analysis.

6.4.2 Post-counselling

After the end of their therapy, participants were contacted again to arrange a post-counselling interview. The time between the last session and the research interview varied significantly depending on how prompt the counselling centre was at alerting the researcher that a case had been closed. Due to the administrative processes of the centre, cases were often not reported closed until 3 months after the final session. Hence up to 22 weeks elapsed before a research interview could be arranged. However the majority of the interviews were conducted within 8 weeks of the final session, and almost all (90%) within 18 weeks.

These post-counselling interviews were again conducted at the counselling centre and lasted between 30 minutes and 2 hours, with an average duration of just over an hour, and almost all (90%) completed within 90 minutes. At the beginning of the interview, participants were given the project information sheet (see Appendix B) to re-familiarise themselves with the study, and asked if they had any questions. Participants were then asked to complete the CORE-OM questionnaire and construct a Life Space Map as above.

6.4.2.1 Reflection on change using LSM

Once participants had finished their post-counselling LSM and were satisfied that it was complete, the researcher brought out their pre-counselling LSM for comparison. Participants were asked to reflect on the changes they saw between the two maps, with the researcher exploring their perception of the changes and the factors that had allowed the changes to occur, as outlined in section 6.3.3.1 above. This process was audio recorded for future analysis.

6.4.2.2 Reflection on change using CORE-OM

To assist a participant’s reflection on change using the CORE-OM questionnaire, the scores for Wellbeing, Problems, Functioning and Overall were calculated by the researcher during the

interview, and plotted on a graph against their pre-counselling scores and the CORE-OM clinical cut-off scores (see section 6.3.1.7 above). The participant was then shown their pre-counselling CORE-OM questionnaire along with the results graph and asked to reflect on any changes they saw, as outlined in section 6.3.3.1 above. This process was again audio recorded for future analysis.

6.4.2.3 Experience of using LSM and CORE-OM

Following the reflection on change interviews above, participants were asked about their experience of using the LSM and the CORE-OM. The researcher explored the participant's experience of completing each measure, as well as how useful they found each one for reflecting on change (see section 6.3.3.2 above). This process was audio recorded for later analysis.

6.4.2.4 Debriefing and post participation consent

At the end of the interview, participants were asked about their experience of being part of the research project, and whether they had any suggestions on how anything could be improved. The researcher then took participants through the post participation consent process (see Appendix E). Here, participants were asked about what material, if any, they were willing to have published, whether or not they would like to see a copy of any material before it was published, or a copy of the final report after it was completed. Participants were also given the opportunity to identify any details they wanted to be excluded or altered, and what they wanted done with materials once the study was completed.

6.4.3 Follow-up

Approximately 4 to 8 months after the end of therapy, participants were contacted for a final follow-up interview. This time varied somewhat depending on how soon after the end of counselling the post-therapy interview had been conducted, and on the ability of the researcher to contact the participant in order to arrange the interview. The follow-up interviews lasted between 45 and 130 minutes, with an average duration of 1 hour 20 minutes and most (80%) being completed in less than 90 minutes.

As with the pre and post-counselling interviews, the follow-up interviews were conducted at the counselling centre. The interview involved completing a final CORE-OM questionnaire and LSM as above. Participants were again shown their previous LSMs and CORE-OM questionnaires with accompanying results graph, and invited to discuss any differences observed, both over the time since the first interview (see section 6.3.3.1), and between the different measures (see section 6.3.3.2). This was designed to be a collaborative enquiry, involving the researcher checking out his own observations from the data previously collected. Participants were also asked about their experience of taking part in the study, and asked to complete a final post participation consent form. This whole process was audio recorded for future analysis.

6.5 Ethical considerations

In undertaking the study within a ‘real world’ clinical setting, ethical considerations were of key importance to the study. It was acknowledged from the start that participants would be from a potentially vulnerable population, requiring extra care throughout the study. To help protect against possible harm to participants, a number of safeguards were put in place.

6.5.1 Pre study ethical approval

The proposed study was vetted and approved by both the ethics committee of the University of Abertay Dundee and by the board of Cross Reach, the social care arm of the Church of Scotland. Further, the study was designed to conform to the British Association for Counselling and Psychotherapy’s ‘Ethical guidelines for researching counselling and psychotherapy’ (Bond, 2004).

6.5.2 Recruitment considerations

Recruitment of participants was integrated into the existing intake assessment process of the counselling service. This allowed for a trained counsellor to make a judgement as to whether or not to invite a prospective client to participate in the study, depending on the level of vulnerability. Further, the researcher contacted each potential participant in person to discuss the study with them. If it was felt there were any reservations regarding participation, it was made clear to people that they could withdraw from the study without any impact on their counselling.

6.5.3 Pre-counselling interview ethical considerations

It was acknowledged at the start that interviewing clients before their counselling would need to be handled sensitively and with care, especially as the research involved in depth interviews that could potentially touch on a participant’s issues and problems. As a safeguard, it was arranged with the counselling centre that an experienced counsellor would be on hand during and after the interview if required. As a trained counsellor, the researcher was sensitive to the emotional well being of participants and was able to monitor this throughout the interview. Further, interviews contained a debriefing stage at the end where the researcher explicitly checked out with participants how they were feeling, and whether or not they would like further support.

A significant ethical consideration during these interviews was the sensitive nature of the inquiry. Participants were asked to represent the significant things in their life, including anything problematic for them. This required careful handling of boundaries between engaging with participants about the research task, and slipping into becoming a ‘therapist’. It was important here that the researcher did not ‘open up’ things for participants that were more appropriate for ongoing therapy. This was especially significant as the research interview was potentially the first opportunity for participants to talk about things at depth with another person. Here it was important that the researcher not dismiss a participant’s issues, but to try and gently bring the interview back

on track. Of benefit in this situation was the researcher's previous experience of conducting client based research (Rodgers, 2002, 2003).

6.5.4 Post-counselling and follow-up interview ethical considerations

In addition to the precautions taken during the pre-counselling interviews, follow-up interviews contained an explicit post participation consent process. This process was designed to check out with participants the level of detail of material they were willing to have published, whether any specific details should be altered or deleted to maintain anonymity, and what should be done with materials once the study was completed. Participants were also given the option to view any material before it was published, and to see a copy of the final report. This process was repeated at the follow-up stage to give participants a further opportunity to limit the use of any material gathered.

In conducting a pre-post counselling study, there is a potential conflict between the research objective of gathering as much follow-up data as possible, and the need to respect a participant's right to withdraw. Though obvious when a participant explicitly states that they want to discontinue with a study, this is not so clear when this withdrawal is more implicit. For the present study, this was an issue in that the researcher contacted participants by phone at the end of their counselling. If participants were not available, a message was left for them to contact the researcher. If participants did not contact the researcher after some time, the researcher would make a further call, and leave another message. Clearly, there is a line here between making reasonable efforts to contact someone, and needing to acknowledge a participant's implicit withdrawal from the study. In this case, the decision was made to only make 3 consecutive attempts to contact a participant before withdrawing them from the study.

6.5.5 Data storage

To ensure participant's confidentiality, data was stored in an anonymised and secure manner. Any forms containing participants' names such as initial contact sheets and consent forms were stored in a locked filing cabinet. Data gathered from participants was only identified by a unique numerical code, and kept separately from their names and contact details.

Electronic data was stored on a secure, password protected computer system. Further, all sensitive material such as interview recordings were digitally encrypted such that only the researcher could access this data. This ensured that no other users of the computer system could access this data either locally or remotely, even if the computer was stolen or 'hacked'. In addition, all data was securely 'backed up' to guard against data loss. (See 6.3.4.4 Secure data backup above for details)

6.6 Analysis

Both quantitative and qualitative analysis of the data was undertaken to provide a variety of ‘views’ of the collected data. The aim of this approach was to demonstrate the different ways of looking at the outcomes of counselling and psychotherapy (see Section 5.2 for a discussion of pluralistic approaches to research).

To give a full and in-depth representation of one participant’s account from the collected data, a detailed case study was undertaken. Here the interview recordings, Life Space Maps and CORE-OM questionnaires for one individual were used to construct a rich narrative account of the client’s perspective on change, along with the utility of the different methods.

In comparison, the CORE-OM questionnaire data for all participants was analysed using standard quantitative procedures as recommended by the CORE system manual (CORE System Group, 1998). Additionally, more recent procedures for analysing this data were employed including the use of severity indicators and new guidelines for determining reliable and clinically significant change (Barkham et al., 2006). This analysis gives a traditional view of the outcomes of therapy within a clinical setting, and makes it possible to draw comparisons with other similar studies.

To give a broader view of the diversity of the collected data, a montage of Life Space Maps, CORE-OM outcome graphs and brief narratives was constructed. Here the Life Space Maps were not formally analysed at all, but rather used to give an unedited ‘picture’ of the outcomes of therapy from the participant’s own perspective. The CORE-OM graphs were created from the previous analysis of the CORE-OM questionnaire data.

A detailed thematic analysis of participants’ experiences of using the two different methods was undertaken to discern the significant themes within the research interviews regarding the advantages and limitations of the CORE-OM and LSM for investigating the outcomes of counselling and psychotherapy. Here the participants’ experiences of completing each method, as well as the utility of each approach for reflecting on change were analysed. Further, a brief thematic analysis of participants’ experiences of being part of the research was undertaken.

6.6.1 Case study analysis

The intent of the case study is to give a ‘rich description’ (Denzin & Lincoln, 2000) of one client’s engagement with the research study. Though the client’s words are used extensively to relate the key narrative themes which emerged from the interview process, all identifying details are anonymised and disguised. The researcher compiled segments of each interview together in order to give a coherent illustration of the main themes of the person’s ‘story’. While clearly there are

alternative ‘stories’ within each theme, the aim was to relate the overall ‘picture’ of what the client had talked about in each of the interviews.

It is acknowledged that while the case study is an attempt to convey the participant’s ‘story’, it is not claimed to be a ‘true representation’ of this client’s experience. The researcher actively constructed the presented narratives from various segments of each interview. In so doing, the client’s own narrative structure is lost. Further, the various pauses and changes in inflection, along with the verbal encouragers from the researcher such as “uh hm”, “aye”, “yeah” etc were excluded. Hence the ‘flow’ and emotional qualities of the interview are not accurately represented. Similarly, the dialogical nature of the interview is lost in terms of the client’s words being a response to specific questions or comments by the interviewer, as well as being in response to the activity of drawing the LSM. As such, the dangers of presenting the case study as an uncomplicated reflection of the clients ‘lived experience’ are acknowledged.

Further, Silverman (2004) critiques the tendency for qualitative researchers to make claims to being closer to ‘the actor’s perspective’ as being somewhat ‘romantic’, overly privileging a naïve phenomenology which does not adequately take into account the constructed nature of the research interview, or the gap between beliefs and actions, and between what people say and what they do. From this perspective, it is acknowledged that the case presentation method used in the present study is indeed ‘naïve’. However, it is not the intent of the researcher to present a detailed discourse, linguistic, or conversational analysis of the interview data, nor to be a deeply reflective account by the researcher of the how the interview material has been co-constructed. Instead, perhaps the most useful way of framing the case study is to consider it a basic example of an approach which “treats interview data as accessing various stories or narratives through which people describe their worlds” (Silverman, 2000 p.823). From this perspective, it can be argued that the case study method used here presents a plausible account of the participant’s engagement with the Life Space Mapping task and completion of the CORE-OM questionnaire, as well as the utility of these methods for evaluating the outcomes of their therapy.

6.6.1.1 Narrative construction of the case study ‘storylines’

McLeod (2001c p.105) outlines a number of key steps in the construction of a case narrative:

- 1) An interview schedule is used that encourages informants to tell their stories.
- 2) Interview data are collected from a number of informants to enable an understanding of different experiences and themes.
- 3) A few key informants are selected whose stories can be viewed as ‘typical’ of broader themes in the data.
- 4) The interview material from these key informants is subjected to detailed transcription and closer reading.
- 5) Exemplar narratives from within these interviews are selected for use in a paper or report.

- 6) The paper or report is written *around* the intact narrative text, which is reproduced in full.
- 7) The goal of the analysis is to assist the reader to understand the meaning of the informant's experience.

Following this guidance, the researcher first became immersed in the transcripts of the interviews. Further, the original audio recordings were listened to so as to get a 'feel' for the significance to the participant of various segments of the interviews. This allowed the researcher to give different segments and excerpts from the transcript the appropriate 'weight' with regard to the participant's overall story, rather than taking comments and statements out of context. From this process, key themes emerged along the domains of 'Problems', 'Causes', 'Resources', 'Changes', and 'Attributions'.

These domains both emerged from interview data and were also constructed by the researcher in order to create an overall organising structure for the presentation of the various themes. Here the influence of the researcher's experience with other semi-structured change interview protocols can be seen. In particular, the Client Change Interview (Elliott, 1999) (see Section 2.3.3 in the literature review) contains the domains of 'Changes', 'Attributions' and 'Resources' which were also adopted for the present study. As such, the emerging 'story lines' are seen as a co-construction of the researcher and the participant. The participant's words can be seen as both an attempt to respond directly to the researcher's questions, but also as a way of 'telling their story'. As such, the narrative analysis was an attempt to reconstruct the main threads of the participant's story within the context of them responding to explicit research questions.

6.6.1.2 Summary and rating of narrative themes

In addition to providing a detailed narrative account, an attempt was made to summarise the emergent themes into tables to try to give an overview of the problems, causes, resources, changes and attributions. To facilitate an overview of the shifts in these themes from pre-therapy through to follow-up, a tentative rating scheme of the extensiveness and significance of each theme was constructed. Six levels were used to describe the presence of each theme, from 0 = 'Clearly absent / Not applicable' through to 5 = 'Extensively present / significant' (see Table 6-3). The main reason for using a 6 point scale was to facilitate a form of comparison with the CORE-OM severity levels detailed below. Different shades are used to help visually indicate the patterns of change at different stages.

Here it is important to note that while this method offers some scope for 'scoring' the client's narrative around problems, causes, resources etc the main intention was to give a flavour of the shifting patterns of each theme within the client's narrative from before therapy to after and at follow-up. Further, this scoring should not be considered a direct scoring of the client themselves, but of their narrative. Though comparisons with CORE-OM can potentially be made, there is a

distinct difference between the two approaches. With CORE-OM, the client is explicitly asked about a broad range of problems, while with the LSM the client is free to mention only those issues that are most relevant to them at that time. Hence, for example, a problem may still be present for a person, and indeed rated on the CORE-OM, but may not be mentioned in the client's narrative as other issues are of more immediate concern.

Level	Description	CORE-OM severity	Shade
0	Clearly absent / Not applicable	Healthy	
1	Minimally present / significant	Low level	
2	Briefly present / mildly significant	Mild level	
3	Moderately present / significant	Moderate level	
4	Moderately to Extensively present / significant	Moderate to severe	
5	Extensively present / significant	Severe level	

Table 6-3 Levels of narrative extensiveness and significance

6.6.2 Quantitative analysis of CORE-OM data

Data from the CORE-OM was entered at pre-therapy, post-therapy and follow-up into a spreadsheet which automatically calculated the individual domain scores for Wellbeing, Problems, Functioning and Risk along with the value for All and All minus Risk as per the CORE system handbook (CORE System Group, 1998). Additionally, severity levels (see Table 6-1 above) were calculated to identify shifts between clinical and non-clinical scores utilising the more recent clinical cut-off value of 10 recommended by Connell et al (2007). The recommended reliable change index (RCI) of 5.0 (Barkham et al., 2006) was used to indicate participants who had demonstrated statistically reliable change from pre to post-therapy. These calculations were combined to provide an indicator of all participants who had achieved both clinically significant and statistically reliable change – i.e. their overall CORE-OM clinical score had shifted from a clinical range above 10 to below this value *and* the magnitude of this shift was greater than 5.

6.6.2.1 Analysis of CORE-OM severity levels

CORE-OM severity indicators provide a simple method for interpreting the clinical significance of a participant's overall score. Barkham et al (2006) provide a table of severity levels which was adapted to give a summary of the severity distribution at pre-therapy, post-therapy and follow-up. Changes in the severity levels (see Table 6-1 above) of participants were compiled to provide a summary of the shift in distribution of CORE-OM scores. To aid the interpretation of this data, and to provide a comparison with the narrative rating scheme (see Table 6-3 above), severity levels were assigned an ordinal number from 0 to 5, with 'Healthy' being 0 and 'Severe level' being 5.

Additionally, to help visually distinguish patterns of change over the duration of the study, different shades were used for each severity level as indicated in the table below

Level	CORE-OM severity	CORE-OM score	Shade
0	Healthy	0 to 5.99	
1	Low level	6 to 9.99	
2	Mild level	10 to 14.99	
3	Moderate level	15 to 19.99	
4	Moderate to severe	20 to 24.99	
5	Severe level	25 to 40	

Table 6-4 CORE-OM severity level indicators

An overall analysis of severity levels was also conducted for all participants who took part in the study demonstrating the change in numbers of people per severity level at different stages of the research. For each severity level, the number of participants with an overall mean score within the range of that severity level was totalled at pre-therapy, post-therapy and follow-up. This gave an indicator of the change in distribution of participants' severity levels at the different stages of the research. Finally, an analysis of the retention of participants who presented with different severity levels was conducted. The number of participants with an initial pre-therapy mean score within each of the severity levels was accumulated for those who had dropped out before the post-therapy interview, for those that had attended the post-therapy interview only, and for those that had gone on to the follow-up stage. This gave an overall indicator of the pattern of dropout from the study, and whether or not participants with more severe problems had dropped out earlier.

6.6.2.2 Analysis of reliable and clinically significant change

As proposed by Jacobson and Truax (1991), an analysis of statistically reliable and clinically significant change was undertaken (see section 6.3.1.5 above). Using the most recent clinical norm data available (Connell et al., 2007) the magnitude of the difference between the CORE-OM mean post-therapy score and the mean pre-therapy score was used to indicate whether reliable change had occurred. For this difference to indicate statistically reliable change, rather than the difference being potentially due to chance or measurement error, it must be at least the value of the 'reliable change indicator' (RCI), in this case a value of 5.0. For clinically significant improvement to occur, the CORE-OM score must move from the 'clinical' range to the 'general population' range. Using data provided by Connell et al (2007), the recommended clinical cut-off value of 10.0 was used for this calculation. Combining these criteria where participants moved from a score of 10.0 or over to a score under 10.0, *and* when the magnitude of this change was greater than or equal to 5.0, provided an indicator of reliable and clinically significant change.

6.6.2.3 Effect size calculation

Effect size calculations make it possible to provide an indicator of the significance of the difference between pre and post-therapy scores compared to the variance of the scores – i.e. the overall ‘size’ of the effect of therapy taking into account the variation in the sample being measured. This also provides a way to standardise measures across studies so that results can be compared. There are, however, a number of different ways to calculate the effect size. For consistency, the method chosen for this study is that used by Stiles et al (2006), whereby the effect size is calculated as the mean difference between pre and post-therapy scores divided by the pre-therapy standard deviation.

Effect Size =	[Mean post-therapy score] – [Mean pre-therapy score]
	Standard Deviation

Different people offer different advice regarding how to interpret the resultant effect size, but the most accepted opinion is that presented by Cohen (1992) where 0.2 is indicative of a small effect, 0.5 a medium and 0.8 a large effect size.

6.6.3 Montage construction

A series of caselets consisting of Life Space Maps, CORE-OM graphs and brief narratives was constructed to form a montage of results (Denzin & Lincoln, 2000) (see Section 5.3) offering differing views of the collected data. Cases were selected on the basis of representing diverse styles of Life Space Maps, as well as interesting CORE-OM outcomes. Brief narrative accounts were constructed from listening to interview recordings, transcribing the text on the Life Space Maps, and incorporating demographic data along with the analysed CORE-OM data. Here the researcher refrained from interpreting the content of participants’ LSMs, but rather attempted to present the information primarily from the participant’s perspective.

Life Space Maps were anonymised and resized as necessary. The CORE-OM data was analysed as specified above and graphed along with the clinical cut off points for both overall scores and domain scores. The Life Space Maps were then compiled into overlapping images which could be presented on a single page along side the CORE-OM data. The narrative accounts were then edited down so that they interspersed between the LSMs and CORE-OM graphs in order to create an overall montage sequence of alternating text and images.

6.6.4 Qualitative analysis of in depth interviews

Initial qualitative analysis was undertaken in parallel with data collection so that previous interviews could be used to inform future interview techniques and questions. This is consistent with a discovery-orientated approach to research where the aim is to develop a deeper understanding of the phenomenon being investigated, as opposed to attempting to objectively test a

hypothesis (McLeod, 2001c). In order to maintain the client’s frame of reference as much as possible, the analysis process focused primarily on the recorded interviews rather than trying to interpret an individual’s Life Space Map. Here the maps were primarily a reference point for the participants themselves to gauge the significant changes in their life. As such, they were used in the analysis process primarily to make sense of the participant’s comments and reflections, and to help illustrate and bring a different ‘view’ to participants’ words in the write up of the results.

To facilitate the analysis process, a computer based qualitative analysis program called Atlas.TI was used. This program allowed both the digital recordings and the digitised images of participants’ Life Space Maps to be used directly in the program rather than relying on typed transcripts alone. Each interview was separated into segments representing a participant’s process of completing the CORE-OM and the LSM, their reflection on the changes they saw using each method, their experience of using each method for reflecting on change, and finally their experience of participating in the research project in general.

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table 6-5 Phases of thematic analysis (Braun & Clarke, 2006, p.87)

Interviews segments were coded using a thematic analysis along the lines specified by Braun and Clarke (2006, see Table 6-5 above). First the researcher became immersed in the data by reading the transcripts, listening to the digital recording segments, and absorbing the Life Space Maps and CORE-OM data. Next initial codes were generated entailing both a process of summarising the data and explicating implicit meaning (Barker, Pistrang, & Elliott, 2002). Themes were then identified both inductively (i.e. bottom up) and deductively (i.e. top down). The inductive approach entailed sticking closely to the words of the participants such that the themes were strongly linked to the data, similar to the processes undertaken in Grounded Theory analysis (Glaser & Strauss, 1967). In comparison, the deductive approach utilised the researcher’s theoretical understanding

developed through the literature review and previous knowledge to inform the construction of themes. Thus themes and codes were labelled using a combination of the participants own words, metaphors, and the researcher's theoretical sensitivity. Themes were reviewed using both psychological reflection and constant comparison until a coherent and integrated structural representation was achieved (Barker et al., 2002).

Additionally, the analysis entailed attending to the 'felt sense' (Gendlin, 1981) of the process. Rather than being a purely cognitive process, the researcher used an embodied exploration to search out meaning at various stages. Various symbolisations in terms of words, phrases and descriptions were 'tried out' and modified until they 'fit' the data in an embodied sense. This is similar to Rennie and Fergus's (2006) articulation of embodied categorisation, which they previously referred to as things 'rising from the gut' (Rennie & Fergus, 2001). Here categorisation is described in terms of working back and forth between the researcher's own experience of a phenomenon (both experiential and theoretical) and the participant's account of the experience of it until an adequate sense of fit is achieved. This involves a process of struggling to come up with words or phrases that sufficiently symbolise the phenomenon, or at least an aspect or portion of it. Rather than being static, this symbolisation may change and adapt in a hermeneutic fashion as the analysis progresses. Throughout this process, the researcher utilises an embodied felt sense in order to determine how a given symbolisation needs to be modified in order to incorporate the new understanding.

6.7 Researcher reflectivity

The research procedures described above involved an extensive reflexive journey on behalf of the researcher. Having completed the study, I can now look back and consider the process from a different perspective. Below are my thoughts and reflections on the process which may be of value for others conducting similar forms of research, or in utilising the Life Space Map approach in other settings or applications.

6.7.1 Prior expectations

On beginning the study, I had a clear belief that the Life Space Map approach would prove to be far superior to the CORE-OM in terms of being a valuable tool for participants to reflect on their experience of counselling. As indicated in the preface, I just did not see the value for people in reducing their experience to a few tick marks on a sheet of paper. As the study progressed, however, I soon became aware that I had misconstrued the significance of these tick marks. My participants were reporting how they could make valuable use of the items on the CORE-OM to 'check in' with themselves, and found that the objective nature of the questionnaire made it easier to see definitive change over the duration of therapy (see the results and discussion chapters for details of these and other findings relating to the value of the CORE-OM for participants).

I am now convinced that offering clients a range of tools for reporting their experience of therapy is the best way forward for counselling and psychotherapy outcome research. Rather than seeing methods in competition to each other, I have come to see that different methods offer participants a variety of forms for expressing themselves, that each different approach ‘allows’ a person to express themselves in a different way. Further, I see that different people have different preferences, that some forms of outcome reporting ‘fit’ better for some participants than others. This has furthered my belief that how we ask the questions shapes the answers we get, and that only by employing a range of measures and methods can we hope to explore the subtleties and nuances of participant’s experiences of therapy.

Reflecting on this process, I can see the importance of holding prior expectations ‘lightly’, of being open to new understanding and meaning to emerge from a study. Whilst this may seem obvious in terms of exploratory research, this feels a very different process to undertaking research which attempts to ‘prove’ something. For me there was genuine surprise at what I was discovering, and I could feel myself becoming more ‘open’ as the study progressed. Further, there was a sense of needing to honour what my participants had to say, of prioritising their view and experience over mine, such that I was forced to change my views out of respect for what they were telling me. Here the openness and simplicity of my primary research question helped in terms of genuinely enquiring into ‘what happens’ when collaborative methods of enquiry are utilised, rather than adopting a more complex or sophisticated hypothesis.

6.7.2 Engaging the counsellors in the research

In designing the study I explicitly chose not to directly engage the counsellors of the participants as I felt clients would feel freer to talk more openly about their experience if they knew their counsellor would not be informed in any way. Additionally, I did not want counsellors to alter the way they worked because they knew their client was part of the research. On reflection, I am now less concerned with research influencing people’s experience, as from the client’s perspective this has proven to be a largely beneficial process. Further, clients did not seem to be concerned about their counsellor finding out about what they had said, but rather felt that it could be useful feedback for the counsellor.

Not engaging the counsellors in the research also had a number of practical implications. In particular, delays occurred between when the pre-therapy interview took place and when therapy actually began as there was no coordination between researcher and counsellor. Further delays occurred between the end of therapy and the post-therapy interviews as the counsellor had no way of directly informing the researcher that counselling had finished. These delays could have been reduced if the researcher had direct contact with each participant’s counsellor so that research interviews could be more coordinated with the therapy. Additionally, any issues with participant

recruitment could have been checked out, and feedback obtained on any reasons given by clients for declining to participate.

Overall, I now feel the benefits of engaging counsellors more directly in the research process would probably have outweighed any negatives. Not only would research interviews have been carried out in a more timely fashion, but the counsellors in the centre may have felt more informed about and engaged with the research, hence influencing how they presented the research to potential participants at the pre-counselling intake assessment interviews. Perhaps more significantly, the research project could have been undertaken as more of a collaborative venture between myself, the counsellors and their clients. This would have offered the opportunity for a more integrated approach to the study in terms of seeing how the research interacted with the counselling, and the subsequent impact on therapy outcomes.

6.7.3 Engaging the participants more fully in the research

Following from the above, whilst the participants were seen as valuable contributors to the research, the study was not conducted in as collaborative manner as it might have been. In particular, as the analysis and write up of the research were completed a number of years after data collection, I felt I could not re-engage participants in a collaborative exploration of the results and get their own reflections on this. This was partially due to my own embarrassment about taking so long to get the task done. However, I also felt that it would be outside the remit of what participants had consented to, especially as during the original consent process I had intimated that the study would be completed within a year or so. Little did I foresee the years of struggle ahead and that it would in fact be almost 5 years before the write up of the results was completed.

Reflecting on this, I feel that I have potentially placed too much of my own ‘voice’ in the results of the research, and have not given sufficient space for that of my participants. I am left with the feeling that whilst revealing in many ways, the results still fail to fully tap into the huge potential of participant reflexivity. Further, I am aware that what is presented in the results of the study has been constructed from my own interpretation of what participants related to me. Though this is something of the nature of research conducted in this form, it also feels to me that I have potentially misrepresented or just ‘missed’ some of the important points that my participants were trying to communicate to me. Without explicitly checking this out with them, I have not had an opportunity to hear this. Perhaps most significantly, I feel I have insufficiently met one of the recommendations from my own study, that data should be offered back to clients in a way that allows them to make use of it for their own growth process.

6.7.4 The process of constructing the Life Space Maps

Though the theory underpinning the Life Space Map approach (see Section 3.1 for details) has proven to be valuable in terms of constructing a theoretical conceptualisation for the method, on

reflection it has also overly complicated the task of constructing the LSM. In particular, I now see that the Life Space Map instruction sheet (see Appendix F) attempts to incorporate too many aspects of the theoretical model. For example, the instructions refer to “what forces are around?”, and “try to indicate on your map where you feel your life is heading. Are you moving towards or away from certain things?” and “what/where are the important boundaries, where one thing or area of your life space comes up against another one?”. These questions were all designed to directly relate to Lewin’s (1936) theory of the spatial qualities of the life space (see Section 3.1.3.3), that ‘psychic forces’ exist which have vector like qualities of speed and direction, and that boundaries between regions of the life space have varying degrees of solidity, resistance and permeability.

Whilst interesting theoretically, very few participants seemed to engage with these aspects of the instructions, and their inclusion makes the task of creating an LSM seem overly complicated and complex. Instead, it may have been more helpful to include further hints and ideas on how to begin the mapping process as this proved to be the single most problematic point of the method for participants (see the results and discussion chapters for details). For example, suggesting that people could start by drawing a circle in the centre of the page representing themselves may have helped, or start by just drawing a random scribble or squiggle on the page to get them going.

With regard to the actual construction of LSMs by participants, this proved to be a highly variable and idiosyncratic process. Some people seemed to engage very naturally with the process and did not need much encouragement or direction. Others did not know where to begin and struggled to get something down on paper. During the mapping process, some participants spoke at length about what they were drawing and what this represented. For others, this was a silent and introspective process, and only after the LSM was completed did they talk about what they had done. For some participants the whole process had a ‘functional’ quality, that it was a specific and ‘contained’ task. However, for some people the process was very emotional and needed a great deal of care in order to maintain a research focus rather than slip into things that were more appropriate to therapy.

6.7.5 The experience of doing the research interviews

The design of the study involved in-depth interviews with people before their therapy began asking them about any things they were experiencing difficulty with in their life, or any areas of tension or conflict. This inevitably brought up a lot of emotional content for some participants. Here I found my training and experience as a counsellor both a help and a hindrance. On the helpful side, my experience of attending to people in emotional distress meant that I did not ‘pull away from’ or otherwise ‘abandon’ participants when they became upset or touched upon difficult emotions during the interviews. This allowed me to sensitively hold the process and reaffirm the emotional significance of participants’ experiences, while at the same time reminding them that therapy would be the best place to explore things further.

On the unhelpful side, my tendency to empathically reflect things back to participants meant that sometimes interviews went ‘off track’ from the focus of the main research questions. Further, this had the potential to deepen participants into less processed material which could bring up difficult emotions. Whilst this was usually experienced as beneficial overall, at times it was quite distressing for participants. Further, it meant that research interviews tended to be quite long, as participants would talk at length about what was going on for them.

There is a balance here between being supportive of each person’s process, and holding a research focus. Further, there are issues around how appropriate it is to offer a depth of engagement which creates a potentially therapeutic space but which is then withdrawn rather than being consistently maintained on a regular weekly basis as would be the case in therapy. On reflection, I feel that I sometimes got this balance not quite right. I have become more aware of the importance of boundaries, both in terms of time and psychological ‘space’. If I was to conduct the interviews again, I would be more likely to gently and respectfully bring participants back on track earlier, rather than empathically follow the person as they went deeper into their difficulties and problems. Though this may have resulted in slightly less ‘rich’ data, I feel that on the whole this would have been more beneficial for both participants and myself as the researcher.

6.7.6 Reflecting on reflexivity

As previously stated, the research project has been an extensive reflexive journey. Reflecting on this, I can see a number of key points that assisted this journey. To start with, I found the experience of constructing my own Life Space Map (see Figure 6-2) and CORE-OM to be an important element of the study. Not only did this sensitise me to the hermeneutic nature of the experience creating an LSM, it also provided a point of reference for me to look back on at the end of the study. This allowed me to see the value of a visual method for re-evoking past situations and feelings first hand, and to experience something of what it was like for the participants in the study. Further, the CORE-OM gave me a tangible ‘score’ to reflect on, to be able see definitive change over time. Additionally, completing the CORE-OM gave me an insight into the idiosyncratic nature of people’s responses. In completing the CORE-OM, I was able to see how my own responses to specific questions sometimes had a different meaning to that which I knew the measure was aiming at. Further, I was able to experience the affirming nature of the questionnaire in terms of seeing that though I was experiencing stress and anxiety from undertaking my PhD, this was nowhere near the level of some items on the questionnaire such as “I have felt panic or terror”. These processes facilitated a feeling of being more of a ‘co-participant’ along with allowing a deeper engagement with the research data than would have been possible from adopting the stance of being an ‘objective researcher’.

Flexibility and openness to the ‘felt sense’ of things has been a further key point along the journey. For example, as a result of completing the LSM and CORE-OM myself, I have had first hand

experience of what it ‘feels like’ to complete these measures rather than being a purely conceptual engagement. This ‘feeling’ quality further informed the qualitative analysis of the interviews. As indicated above (see Section 6.6.4), the interview analysis process entailed being open to what ‘rises from the gut’. This was a very embodied process, of allowing myself to ‘not know’, to not impose meaning but to allow this to arise. As this meaning arose, it became accessible to my cognitive, more analytic mind which could then shape the words used to describe each code and category. Reflecting on this process, I can see both the ‘organic’ nature, as well as the more ‘mechanical’ process of analysis. Both aspects needed to come together for this process to work. With purely ‘organic’ processing, meaningful words could not take shape. With purely ‘mechanical’ processing, the more subtle nuances of what participants related would be lost. Only by going back and forward between these processes could a fuller representation be constructed of what participants were relating.

A further feature of reflexivity with regard to the study was the role of peer and supervisor support. There were times when I felt quite ‘lost’ in the data, buried beneath a mountain of interview transcripts and unable to ‘see the wood for the trees’. At other times, I felt quite despondent, that there was just no way I was going to be able to bring all the disparate parts of the study together. At these times it was invaluable to have an ‘outside view’, someone to help put things into perspective. Here my supervisor was able to help me stand back from the study, to allow me to “see what you’ve got”, rather than being consumed and entrenched in the process. Further, his comments or reflections would often spark new strands of thought or lines of enquiry, allowing further progress to be made when previously everything felt ‘stuck’ or overwhelming. Reflecting on this, I can see the huge potential benefit of conducting research in a team setting rather than as an isolated individual. Having others around that one can regularly bounce ideas off, to reflect on and talk things through with, who are also engaged in some form of related study feels much more supportive and facilitating than a lone trek through the wilderness of doctoral research. To anyone thinking of conducting similar research, I would highly advise utilising whatever peer support you can, and preferably cultivating a team of people with whom to make your journey.

7 RESULTS

The results from the study are presented in five parts intended to give different perspectives and ‘views’ of the collected data. The first part presents an in depth case study designed to give a rich narrative account of one participant’s experience. As a comparison, a more traditional presentation of results in the form of the quantitative data from the CORE-OM questionnaire is presented in tables and graphs. This is followed by a montage of a variety of styles of Life Space Maps and CORE-OM graphs showing the differing views of outcomes for a selection of participants. Following this, a thematic analysis of participants’ experiences of using the two different methods is presented. The final section presents a summary of peoples experiences of being part of the research project as a whole.

7.1 Part 1: Case Study – the story of Andrea

This case study is of a 58 year old woman who presented with depression. ‘Andrea’ (a pseudonym) initially went to her GP where she was prescribed antidepressants. She lived alone and was unemployed living on government benefits. Andrea had experienced counselling at the centre around 15 years previously which she had found beneficial. She attended the current counselling for 11 sessions over a 3 month period. Following is a presentation of the initial interview and Life Space Map construction process, along with some of the main ‘story lines’ to emerge from the process. This is followed in a similar way by the post-therapy interview and mapping process, and finally the follow-up process. Following the detailed narrative accounts, a summary of the main narrative themes is presented including a representing of the shifts in narrative at different stages of the study. At the end of the case, the CORE-OM outcome data are presented.

7.1.1 *Andrea’s pre-therapy Life Space Map interview*

After completing the CORE-OM questionnaire (see Appendix G), Andrea was shown the Life Space Map introduction sheet (see Appendix F) and asked to draw her map. The process took approximately 55 minutes to complete and started with the researcher saying “*Feel free to start wherever you like. The idea is to sort of ‘map out’ the significant things that you see in your life at the moment. Feel free to ask any questions as we go*”. In response to this, Andrea started drawing and a few minutes later said “*This is where I feel... I feel quite lost and have probably reached the stage in life that I just don’t know where I’m going...the dark lines...like a prison. Probably due to sort of a history of lots of turmoil and anxiety...*” Throughout the interview, the researcher made empathic reflections on what Andrea was relating such as “*A lot of stuff that you carried with you...*”, as well as more empathic conjectures such as “*Slightly detached from it in a way?*”.

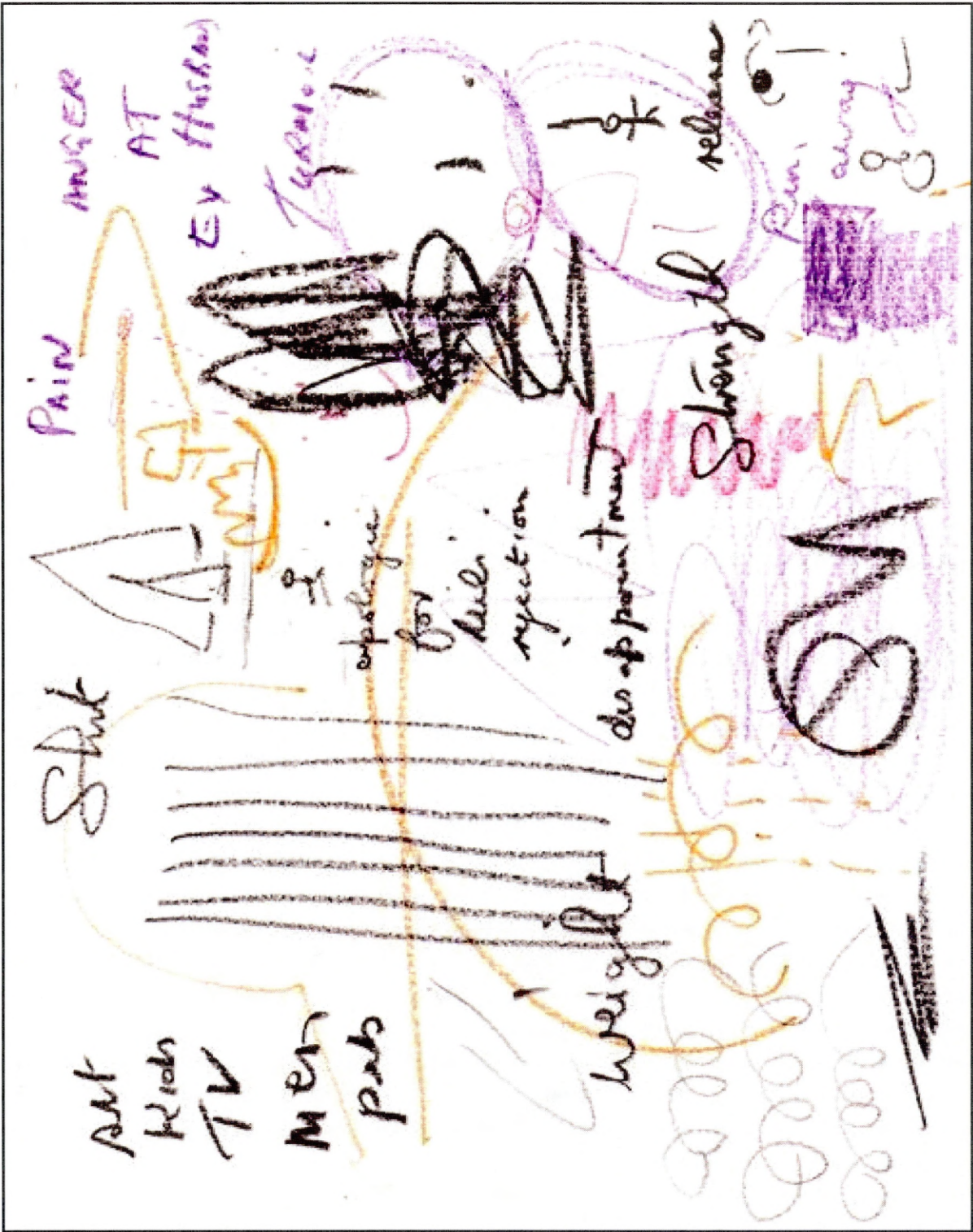


Figure 7-1 Andrea's pre-therapy Life Space Map

This process continued with Andrea drawing and speaking at the same time, sometimes putting down words directly on to the map such as “*Pain*”, “*Anger at ex husband*”, “*Strength*” etc. At other times, problems were referred to more pictorially. For example, “*So it’s all been hurdles and hurdles and these mountains*” in her problem narrative below refers directly to the picture of mountains in her LSM. Similarly “*that’s me sitting there in this wee flat just feeling blocked in*” relates directly to her drawing.

There were also more abstract representations and reflections, like when Andrea described feeling lost at the beginning of the interview saying “*...the dark lines...like a prison*”. Here there is a slightly different quality to the mapping process, where rather than a diagram being constructed as an explicit representation, the drawing is more abstractly ‘put down’ on paper and then meaning derived upon reflecting on it. This was particularly evident toward the end of the interview when Andrea commented “*That’s ridiculous looking at this. This is all so negative. But obviously there’s something in there that’s... A lot of anger there. You know what I mean?*”

Similarly, throughout the interview there were times of spontaneous personal reflection where Andrea would comment on the mapping/interview process itself. For example, “*Where did all that come from? {screams aahhh} This is healthy stuff. This is what I should be doing more often, getting it out. You know what I mean?*” and “*This is quite good actually. I find this quite good really because I’ve seen programmes on the TV and they say getting it down on paper helps to empty anger or understand your anger – understand how you’re feeling. Maybe I should be doing this more at home instead of sitting there on your own being bored get a bit of paper and go aaaah. Sometimes you just want to scream. You know and maybe that’s just quite therapeutic stuff. Just to actually go ughhhhh.*”

7.1.2 Andrea’s pre-therapy narratives

This pre-therapy LSM interview generated a number of key narratives which can be seen as Andrea ‘telling her story’ in response to the request to “explore your view of your life as it is just now”. Specifically, the following storylines emerged: 1) Problem narratives – the main problems that Andrea talked about; 2) Causal narratives – what Andrea saw as the causes or explanations of her problems; and 3) Resource / coping narratives – which relate how Andrea had managed her problems. Detailed extracts from the interview have been compiled below to give a flavour of these key narrative themes.

7.1.2.1 Andrea’s pre-therapy problem narratives

The following extracts convey the predominant ‘problem narratives’ that were present in the pre-therapy interview. These could be considered as Andrea’s ‘presenting problems’, though they were not explicitly asked for or stated in that way. Further, the problems were not constructed in terms

of being goals or issues to be dealt with in therapy. Rather, these ‘story lines’ emerged as part of the process of constructing the Life Space Map and Andrea’s reflections on it afterwards. These problem narratives can be summarised as ‘repeated adult trauma and hurdles in life’ combined with a strong sense of ‘unfinished business with ex-husband’, and a feeling of being left ‘relationally scarred’. Embedded within these narratives were feelings of being ‘abandoned / lost / empty’ along with feelings of ‘guilty / self blame’. Andrea also specifically related that ‘depression’ and ‘OCD’ were significant issues in her life. Following are verbatim extracts to illustrate each of these problem narratives.

Andrea had experienced ‘repeated adult trauma and hurdles in life’:

<i>... my childhood was fine, teenage years were fine, got married and first child was brain damaged at delivery, that was horrendous and I didn't have depression after that it's amazing. I think I just went through on autopilot. I mean my daughter's still alive, she's 32 she's now in a home in the community, so that was brain damage. Next child was sectioned, c-section. He was fine. And then my husband decided to get into social work so he was at college and had the handicapped and the normal child and eventually he couldn't cope so he left. So I was left holding the two of them. And he never returned.</i>
<i>So that damaged my son. So, when he became an adolescent he had a break down. I'm not saying that was the total cause of it, there's obviously lots of causes, but he had a breakdown at 15. A lot of things contributed and when I moved house it just accelerated his problem so he was in hospital for over a year...</i>
<i>What you feel should be a normal okay marriage breakdown, I can accept that, I can accept that. But it would have been nice if he'd seen the boy once a month and kept contact. That would have given me some security for me, and knowing that the boy is seeing his dad. But that wasn't available so that's another hurdle. So it's all been hurdles and hurdles and these mountains. And here we go again another big fucking hill to go up and here we go. When is this going to end?</i>
<i>And then my dad died 2 year ago and I was his carer and I knew he loved me but abandoned again.</i>
<i>And then especially with my daughter going into hospital it brought back the whole, oh my god, you know, here I am, I've brought her up 6 years on my own...How the hell have I got through that without anyone. I must have been on autopilot all those years. And then when she was put into care I had to go through all that pain of parting with her into care at 6. And then I had the boy at home, left on your tod. No ex-husband. How's he doing – nothing, nothing, nothing. Not even any communication</i>

This dominant problem narrative was interwoven with ‘unfinished business with the ex-husband’:

<i>Anger at my ex-husband for just leaving me in all this turmoil you know and doing the job he's doing. I mean how...obviously they can do it just switch off obviously and just get on with his life.</i>
<i>I feel I deserve an apology from him. We planned that child. That boy was planned and to be honest with you that child shouldn't have been without a father, especially when I was married to the guy, it was planned... He should have kept in touch with that boy if he was normal. To actually reject that child...</i>
<i>I mean after having a handicapped child and then having a second child that's going to be damaged because of his lack of contact or interest or you know, all he thought that by this time you'd have met someone else and that you'd have been hunky dory. If I had met someone else are you still not his dad? You are his dad.</i>
<i>And to think that when I was going through this separation, he went off with the fourth one he went out with... she was an occupational therapist. I had a good idea something was going on and then we went on holiday with her you know and I could see it and I just sat there and never said anything. You know and she was quite bossy and I just fell in with the "do this and do that" and I just went along with it and that's not me because usually I would be, get her by the throat and kill her, well not kill her but you know what I mean. I went through just a stage of I don't believe it, don't believe it.</i>

And obviously I'm needing some sort of, I would certainly like to come face to face with my husband to say do you know what the agony you put me through. Maybe you don't care but what you put me through. I hope he loses his job, I hope he gets divorced and I hope he finishes up in the pits, because that's what he deserves.

A further problem narrative revolved around a sense of being 'relationally scarred':

I think I have been scarred by my experience. If he can get up and leave me... So what I do is get into relationships and then get out before they get out. It's a safety valve. Or maybe I don't want it. Maybe I've just been put off by the whole scenario... So I tend to run away. Run away from permanent situations. And I quite like being on my own to a degree but it's the loneliness, you know the not sharing with somebody.

I think what happens to me when I get into relationships I just sort of, just feel that there's no man ever going to do to me what he did to me as in, don't tell me what to do, don't put down your laws because you're not on.

And then I get spells when it's okay and I'm happy and I'm in a relationship and life's brilliant and ah, this is great and then that comes to an end. And it's me that finished it. But for good reasons I mean it's not that I'd actually let somebody go that's was absolutely fantastic. There's been obviously some that I knew weren't going to work anyway at the end of the day well, the pain he caused I don't want that same pain again. So it's a..don't want to get hurt, can't take it.

Within these problem narratives was a further theme of feeling 'abandoned / lost / empty':

There's a lot of ...I feel empty. I felt abandoned...this big emptiness. Big big emptiness. Why? Why me?

I feel sometimes you do get a feeling of being detached from reality. Feel as if you're out there looking in, watching the world going by and people walking about and doing things...so... Losing interest in things.

People let you down all the time. My old dad used to say "depend on nobody but yourself" for whatever because ...there is obviously some nice genuine people out there but very few, very few that I can find anyway. People just let you down.

...even then I was abandoned by the Catholic church because they don't believe in divorce, then more so than now... you don't have cause for annulment because all you did wrong was to marry a wooden catholic, somebody who didn't practice his faith.

Some of these problem narratives seem to have a 'guilt / self blame' quality embedded:

Anger and maybe guilt, I mean my fault that my daughter was brain damaged. Even he told me that, he says even that you couldn't even do that right. My life was in the hands of the consultant. The wrong decision.... Even that you couldn't get right.

And I felt hurt and rotten that this wee lassie that he loved was brain damaged. Look at what I've done. Look what I've done. Unless the two of us could have died and that would have saved a lot of problems because in the old days both of us would have died with the kind of birth she had. She burst through the uterus and got jammed. In the old days both of us would have been a gonna.

So probably there's feelings of guilt, which are I know I unduly felt but it's that the depression has exaggerated the situations...

Throughout her relating of other issues, Andrea clearly saw 'depression' as being a major contributing problem, and that this had resulted in 'OCD':

So it's just really the depression and thinking more positively because there's been quite a lot that I've actually had to handle in the past so...

Losing interest in things. Can hardly say motivation is...that's quite normal. Maybe the depression doesn't help right enough. Feeling kind of fed up....

And the depression gives me that OCD thing, that obsessive compulsive disorder that I'm doing things all the time and I smoke and I'm making sure the cigarette...I think it's an anxiety thing that OCD.

7.1.2.2 Andrea's pre-therapy causal narratives

Along with the problem narratives, there were a number of 'causal narratives' which Andrea used to make sense of her problems. These narratives can be seen as the client's view of the causes of or explanations for her current situation. The strongest of these were 'depression is an illness' that needs to be cured, that it is something physical that has gone wrong and needs to be fixed.

However, she also saw that some 'problems stem from childhood'. Within her immediate life, there was a recognition that 'social isolation' was a cause of her unhappiness, and an accompanying feeling of 'powerlessness'. This sense of powerlessness was also evident in a strong theme of the seeing 'Catholic Church as the source of guilt / injustice / anger'. Below, these themes are again illustrated using detailed extracts from the interview.

Andrea clearly saw that 'depression is an illness', something that is physical and needs to be 'cured' or 'got over':

I'm normally quite an outgoing person and I can get up, which I've had to be for a long time but this time I've felt a sort of illness of depression wherever its came from.

...and they've all {my problems} got out of proportion due to the chemical imbalance in my brain or the way my body's working.

It's unbelievable how common depression is. They say it's hereditary. My mum had it, my sister's had it and I think it's a 50:50 chance if it's in your family but then that's being negative if you think I've got depression, I must have depression my mum had it. I got it but it's still I feel reasonably mild unless I get a bad day. If I get a bad day I just want to sleep. I want to sleep and just wake up feeling that wee bit better.

When you've got depression... At least I have to try and cure this depression, get a bit of counselling and then just get on with my life.

Andrea also made sense of her own and other's situations through seeing that 'problems stem from childhood':

You know I never ever expressed a lot of things going up to my dad... "I'm not coping that well dad". "You've had a raw deal hen", he would say, "you've had a raw deal". And brave me would say, "och well dad that's life, that's life". It's just how you cope with it. But my dad wasn't the kind you could talk to. You couldn't greet in front of my dad.

And my mother wasn't any good to me because she had depression by this time. She was in and out of hospital for years and keeps saying that I hope I don't finish up like my mother. I don't think I will, hopefully. I think I'd have been in there by now you know... It's really where do I go from here. I mean I've got to put that, maybe I should sit and I don't know...

There's questions around how he had more problems than I realised when I took him on. He had problems which I probably didn't perceive, because he was brought up by deaf and dumb parents so he got brought up in silence maybe the reason for he couldn't communicate. Maybe he wasn't very good at communicating, because it was in sign language. So all the uncles and aunts were deaf/dumb so I had to try to pick up a wee bit of sign language. So he got brought up with...maybe the communication just wasn't there...

Within this, there was also a sense of 'social isolation' and 'powerlessness':

...mother's dead, father's dead, the sister that suffers from depression lives her life like a recluse, she's no comfort. I mean, god love her, she's no support. My younger sister has got two kids, no support. Apart from the odd friend but I don't have many friends. I have acquaintances but I don't have folk I can confide in because I really don't trust people.

I don't know why all the past is coming back. I think it's just maybe because I've not been going out so much and I'm sitting there

I sit by the fire, my wee fire, watching the tele. Is this my life now? Is this it? No, it can't be my life. This is terrible.

A further strong causal narrative with some links to ‘powerlessness’ focused on the ‘Catholic Church as the source of guilt / injustice / anger’:

So their {the Catholic Church} belief was that if I had been pregnant before I got married I could have got an annulment, if I had married an alcoholic who battered me about I could have got an annulment. A load of crap. Never heard so much shit in all my life... Crap, I'm sorry, what crap. What mince. You know what I mean. Too severe, too strong, I mean in their eyes I'm still married to my ex husband so I'm supposed to go about with a chastity belt on, cause I'm still married but it's okay for him to get married but I've not to have sex because....oh common, get real. You know what I mean? And I'm fornicating if I have sex. What a lot of brainwashing you get from your faith.

Half these priests are out shagging their parishioners. I mean, who are they kidding. I mean, God you don't mean that for me do you? But I mean I can laugh about it now, but how the hell do these folks live with their manmade laws... God. White wedding, the chapel, the bloody lot, virgin bride. Thank you for the lot.

And the guilt. The guilt that comes from the Catholic faith as well. Right. The fire of the devil. Don't do that, don't do this. Confession this that and the other.

Guilt, guilt, guilt. I think you find that most Catholics have got guilt ridden minds and it's our duty to brainwash a youngster. Unbelievable, unbelievable. Oh, dreadful.

7.1.2.3 Andrea's pre-therapy resource / coping narratives

Along with the problem and causal narratives, there was a thread of resource and coping narratives that related how Andrea had managed so far, along with what she thought she needed to do. There was a real sense of ‘coping and inner strength’ which Andrea drew on throughout her struggles. This had a further quality of ‘survival and getting through it’, of fighting and persevering rather than feeling sorry for yourself. It is clear that Andrea made use of numerous ‘collective helping resources’, that it was not just one thing that helped cope, but a combination of many.

A constant ‘coping and inner strength’ narrative emerged to counter Andrea's dominant problem narrative:

But then again looking back, the pain has brought out a strength, a strength in me that I don't really see in many people I know. But to me it was either sink or swim anyway, so you've either two choices. I mean I've seen folk hitting drugs and god help them. There for the grace of god go I. That could have been me, that could easily have been me.

I'm still hanging in there. I'm hanging in there just waiting to be realised and on my way again. I've just come to a full stop and I'm looking to pass over that and to move on. But I feel I'm at the time of my life that I feel like I should actually go up to my husband and say "how are you doing. I hope life's been good to you. I hope you're happy that he {our son} did well and let's forgive each other". I think I just want to put things to right. I felt I never ever got the chance to do that years ago. He was never there, he didn't come back. He wasn't coping...

See my strength, I've broken your crayon. Thank god for a sense of humour at the end of the day, keeps you going. But I know my boy has felt it. And after you got a handicapped child you get a normal one and he's still getting damaged. I mean, what the hell is it all about? But then again he's got his own strength that we all have. By having his breakdown, the psychiatrist said this has done him good. This has done him good.

That's just the cross you're given to bear and maybe you get that strength to cope with it from whatever source. You get two choices you either cope with it or you go down the tube. That strength. Because I had a son to bring up. So maybe it was a good thing I had him to concentrate on. Deal with him and bring him up.

Within this was a strong narrative around ‘survival and getting through it’:

So this is what I'm trying to fight against to be either over or through into something more positive. Positive and happy in the future and to learn to forgive people who have actually caused a lot of hurt and pain in my life.

When I tell the odd person what I've come through they went "oh my god, I don't know how you've survived like that. Oh, that would have done my head in". But maybe it's doing it in now rather than doing it in then. Maybe it's caught up with me. So it's facing the pain.

Along with utilising 'collective helping resources':

...I have been to my GP, got antidepressants, been to the homeopathic clinic, they've given me some drops, {the counselling} centre. Now and again I go to Time Out. I don't know if you've heard of Time Out it's for people with depression.

And getting fellowship through the church. That has given me comfort, going to church and praying and feeling a bit stronger.

I've always had faith so that's always got me through. Always got me through when I had my daughter. Got me through and then when my son had his breakdown it got me through

7.1.3 Andrea's post-therapy Life Space Map interview

Four 4 weeks after counselling finished, Andrea returned for the post-therapy interview. As with the pre-therapy interview, Andrea was asked to complete a CORE-OM questionnaire, then to construct her Life Space Map. In comparison to the pre-therapy interview, this process was relatively brief lasting approximately 20 minutes. Following the Life Space Map construction, Andrea was shown her pre-therapy map and asked to reflect on what she saw had changed between the two, and about her experience of using the different methods and being part of the research.

Similar to the pre-therapy LSM interview, the process started with the researcher reintroducing the mapping task and inviting Andrea to talk about how she was doing now. Andrea started drawing and said: *"Well I see brighter lights now in my life whereas before I felt quite trapped in my thinking and had a lot of pain and probably self blame that would come into my thinking which was part of the depression in my past. But I feel I've come to terms with a lot of things, I actually feel I've come to terms with a lot of things and a lot of guilt was all in the mind to be honest with you, it was all totally unnecessary.."* Similar to the pre-therapy interview, the researcher made empathic reflections as Andrea spoke such as *"Like things are a lot lighter..."* as well as more empathic conjectures such as *"Almost like something takes over you?"*

This post-therapy Life Space Map was much more 'sparse' than Andrea's pre-therapy LSM. There was only a single direct statement in words – "Mental state is fine", compared to the numerous notes and words on the pre-therapy map. During the interview, Andrea seemed to recall some of the *"dreadful horrible scratching on the paper that I did the last time."* She also seemed to be in a much more settled space in terms of doing the interview, and saw this more as an altruistic opportunity to help others - *"You know I mean that's why I'm here, for you. If this could be of any help to somebody that suffers from depression..."* As such, there did not seem to be moments of spontaneous self reflection as there were in the pre-therapy interview. As with the pre-therapy interview, Andrea made a number of references to her map in the process of relating her story. However, these had a more overall quality rather than picking out specific features – e.g. *"So really my sheet is quite fluffy and quite blank"*.

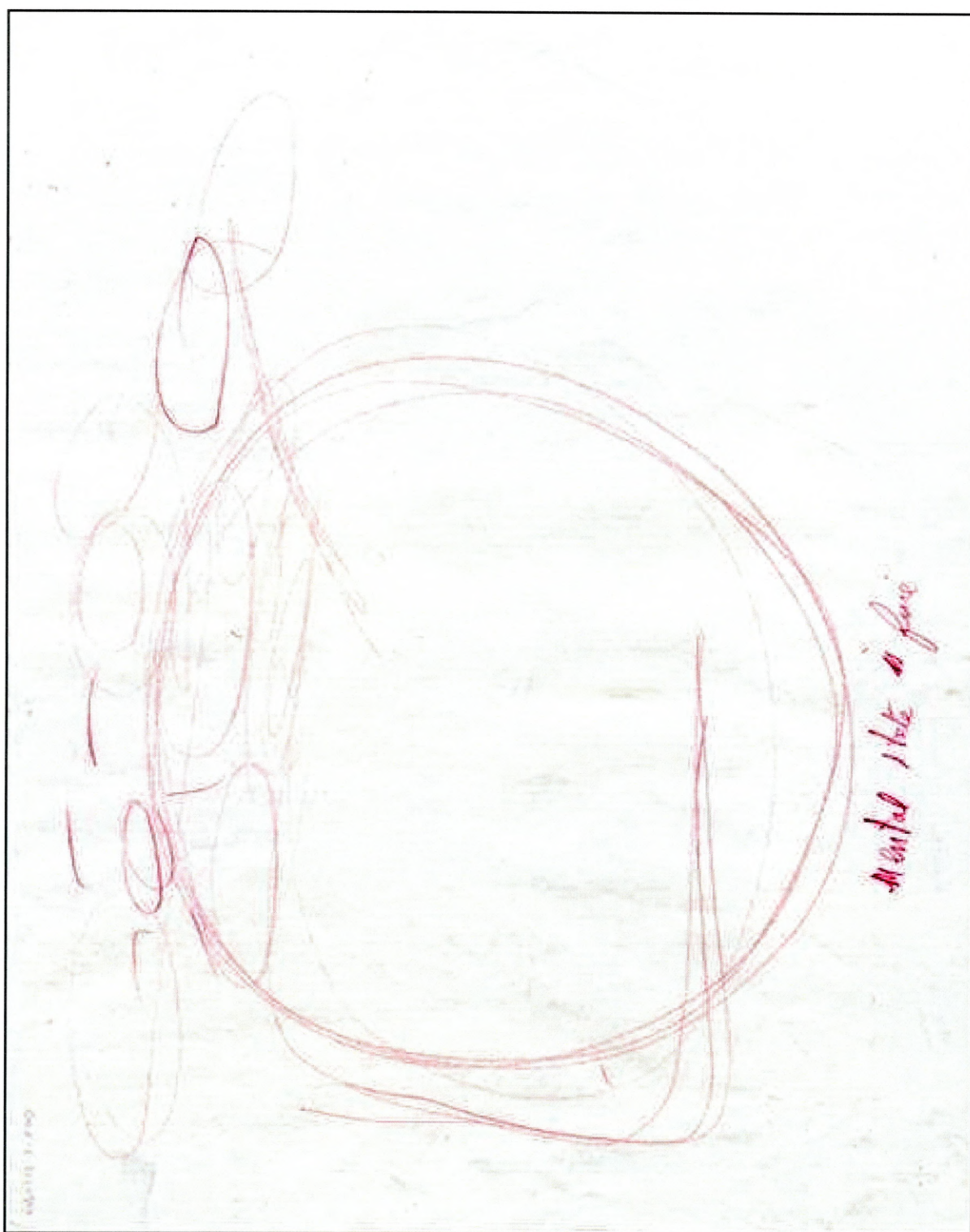


Figure 7-2 Andrea's post-therapy Life Space Map

7.1.4 Andrea's post-therapy narratives

Similar to the pre-therapy interview, the significant themes from the post-therapy interview have been extracted and pieced together to construct a coherent narrative using the client's own words. The themes from the pre-therapy interview have been retained in order to form the basis of a comparison from pre to post-therapy. However, other significant themes which were not present in the pre-therapy interview are also described. These can be seen as being in response to different questions being asked at the post-therapy interview, but some also seem to be indicators of new or different views from the pre-therapy interview. As with the pre-therapy interview, these are collected under the themes of 1) Problem narratives, 2) Causal narratives, and 3) Resource / coping narratives.

In addition to the above, further themes emerged in the post-therapy interview in relation to Andrea's reflections on how things were different in her life. These reflections arose from a combination of Andrea spontaneously reflecting on her memory of her pre-therapy situation as she constructed her LSM, and directly from the researcher showing her the pre-therapy LSM and asking about changes and the causes of change. These reflections have been collected under the themes of 4) Change narratives – the client's view of what had changed, and 5) Attribution narratives – the client's view of what the changes were attributed to. This later stage of the interview took significantly more time (approximately 60 minutes) compared to the LSM construction phase (approximately 20 minutes).

7.1.4.1 Andrea's post-therapy problem narratives

Compared to the pre-therapy interview, there was a distinct shift and reduction in the intensity of the dominant problem narratives. These problem narratives had either disappeared, or became 'restored' into more contained, resolved and reflective narratives. The themes of 'repeated adult trauma and hurdles in life' and 'unfinished business with ex-husband' were still present, but had a more 'processed' quality to them, as if they were not so immediately painful. Significantly, the themes of feeling 'abandoned / lost / empty' and being 'relationally scarred' seemed to have disappeared, while the feelings of 'guilt / self blame' had softened and became more reflective. 'Depression' was still seen as a problem to manage, but there was no mention of 'OCD'. Interestingly, a new, broader problem narrative of 'the world's a mess' became evident, along with a more pragmatic issue around 'alcohol'. Following are some brief excerpts from the transcript of the post-therapy interview around these problem narratives. This brevity reflects the relatively fewer references to problems and issues compared to the pre-therapy interview. This may be indicative of a decrease in the prevalence of these problems for Andrea, but may also be due to a shift in the focus of the interview towards looking more at changes from pre to post-therapy.

The **'repeated trauma and hurdles in life'** narrative was more distant, more **'processed'** and reflective compared to the **'rawness'** of the pre-therapy interview:

I mean it can be horrible when you get depression or you feel so negative about things because of my past experiences with my handicapped daughter, my divorce, my son and it just went on and on and on and my husband left me and he couldn't cope with the handicapped child and I had to get on with it myself and she had to be put into care and it broke my son up and it was a lot of things catching up with me...

I think every now and again I seem to take a slump for whatever reason and I seem to come back because I've used this centre before a way back about 15 years ago. It was when my son was going through some problems I came for help for me for how to handle him because he was going through a very difficult adolescence. He's now outgrown that and he's now a staff nurse and he's done well but he did have a breakdown. He was just going through a terrible time in his life.

Because I went through hell when I was left with two kids on my own... Oh it was horrible. I mean I had a 6 year old in a wheelchair and a 3 year old and off he went ... bye thank you, have a nice life. You know what I mean? Aye. Dreadful. Aye. Frightening. Frightening. So absolutely terrified. Because I'd never been on my own in my life. I left my mum and dad to get married. I'd never been in bedsit land. Living, sharing flats, on your own in a bedsit. Never done that. Never done that in my life. And there was me left with two kids. And he wasn't coming back. Swallow that one. See how you survive through that. That was tough. That was tough. You know what I mean? That was, I had to part with that daughter into care. So I had a kind of death. A death, a living death. And then I had a 3 year old that was probably totally confused. And there was me trying to cope with all that. Oh my god. But I done it. I got there. It's made me stronger for it. But then again, every now and again I get my wee, oh. And then I surface again.

Similarly, the **'unfinished business with the ex-husband'** seemed to have shifted, though there was still a sense of resentment there:

You know she's {my daughter} in the community now. She's severely cerebral palsy brain damaged at birth. He never accepted it and blamed me which ...even that he couldn't do right you know what I mean. My body was in the hands of these doctors who just took the wrong decision. The two of us could have died but I lived and she lived with severe brain damage. He just couldn't take it so, I forgive him because he was young and not very many men can take it. Some women can't take it but I was left and I got on with it so fair enough.

The feelings of being **'abandoned / lost / empty'** and **'relationally scarred'** had disappeared, replaced by reference to a positive ongoing male friendship:

I've got a friend. I've got a male friend that's quite good but he's never had it {depression} so, I'm not saying you have to have somebody that's had it but...he's okay but he tends to cotton wool you but I don't need the cotton, I don't need the cotton wool. Don't keep saying how you feel in the day because you're just being forced and the fact that I had that and I feel much better now and you're just taking me back to it. I'm all right you know. He doesn't give me any space, he doesn't know any different.

The feelings of **'guilt / self blame'** had also softened and become more reflective:

Aha, it's an anxiety that you've did some, you've hurt somebody, you've done some damage or you, oh my god you know. You've injured somebody because I've got obviously a very sensitive personality. I mean, oh have I hurt anybody in that or, and you become so sensitive to, oh god.

Sensitive to "I hurt your opinion or pulled you up wrong". Or "maybe it was my fault he had a breakdown. Oh god maybe it was my fault he had a breakdown. Oh my god maybe I should have sat in every night. Oh god was it my fault?" Blaming self – blame. All this negative self-blame. And it feels so real, at the time it feels oh, so real.

'Depression' appeared to be more related to something from the past, and even as something that was potentially a valuable experience. **'OCD'**, however, was not mentioned at all:

And these depressions can be very temporary things for you to go through that horrible time to come out the other end and go 'oh my god, thank god'.

<i>I've only had mild depression. God this could have been a hell of a lot worse. How do the other folk cope? How ill you were and how you can...oh that was dreadful. How you were not functioning. You were just not functioning, although you appear to function.</i>
<i>And you look at the great people who have had depression, Churchill... Excuse me, I'm one of them. That's my sense of humour. But there have been lots of famous people who have had depression haven't they...</i>
<i>That comforts me... That great people have had it. I'm actually quite, not an unclever person after all. I'm really quite a genius after all (laughs)... All these famous people. Who was that musician who had it... Mozart? Yeah, I think it was Mozart... That's why he could be creative. Because he had this depression... that brought something else out.</i>
<i>Sometimes there's reasons why. To me with depression you actually focus so different. When you're looking at people you can actually see them in a different light. Everything seems so different. It can be a learning process believe it or not in a funny kind of way.</i>

A new problem narrative emerged which was more broad perspective in terms of 'the world's a mess':

<i>I mean the world's a mess. I think the world's a mess. If you go too deep into it. You try to switch off don't you. I mean maybe it's always been like this. I mean I say is it always been like this or is it just me getting older and maybe listening to the news, I mean should you be listening to the news it's all negative isn't it? Negative, negative. So that all absorbs. You absorb all that negativity.</i>
<i>It feeds in negative, negative, negative, negative. I mean, I don't really buy a paper as such. I mean I listen to the news but sometimes I go switch it off. Who needs it? You know what I mean.</i>
<i>I mean okay I've got a bit of compassion for certain issues but some folk just sit and take all that in and it's horrendous. Absolutely horrendous listening to. There isn't any good news now is there? Is there any good news in the papers?</i>

Andrea also mentioned a new, more pragmatic problem narrative around 'alcohol'

<i>Because even with this new medication I was on at first, I could hardly have a drink because as soon as I had a drink I was feeling light headed or even dizzy and not feeling very good because it was interacting with the drugs. And I thought God is ... me I can't even drink. Oh what a thought. I enjoy a drink in moderation. I enjoy a drink but I thought oh my god I can't mix drink with this because it's not much of a life is it really. I mean sad isn't it to have to rely on a drink but it's nice to have a drink isn't it.</i>

7.1.4.2 Andrea's post-therapy causal narratives

Similar to the problem narratives, the post-therapy causal narratives of 'depression as an illness' and 'problems stem from childhood' appeared more contained and reflective. There was also a slight change here in terms of seeing that depression is 'in the genes', but also may be to do with 'problems in thinking'. A distinct shift was apparent in terms of the previous narrative themes of 'social isolation', 'powerlessness' and the 'Catholic Church as the source of guilt / injustice / anger' which had disappeared altogether. Again, this may be an indicator that Andrea had greater acceptance of things at the post-therapy stage, or it may reflect the different focus of the research interview.

Andrea still saw 'depression as an illness', but there was more of an acceptance around this, and perhaps a resignation that it was 'in the genes' and needed to be controlled medically. There was also some indication of seeing depression as 'problems in thinking':

Well my sister's got it. Depression and a breakdown. Young sister had post-natal depression, my dad never had depression. Thank goodness he was fine, he was great... and he lived to 85 which I think was quite a good age, considering that he had emphysema. But he didn't seem to have depression, although he was a worrier, but he never ever got depression. He didn't have that wee gene that caused it but my poor mother did right enough. So I recognize it's a possibility, but there's no point in saying oh my mother had it so I must have it. I don't think that goes hand in hand but there's tendencies that's there a wee bit unfortunately but if it's controlled by an antidepressant I'm quite happy and if my life, if the quality of my life's good then that's fine, I'll keep taking the tablets. End of story. Could be a lot worse.

I don't know what caused it. The chemical imbalance is what causes it. I don't know. I presume that's what depression is, is it? Is it a chemical imbalance in the brain?

I mean my depression might be caused by my thinking, not by this lack of chemical... I mean the brain might have nothing to do with this... It could be my negative thinking could have brought on the depression and maybe the antidepressants weren't required. Once your thinking gets better. Once you're thinking gets into the right mode of survival. I don't know. Anyway as I said I'm feeling better and we don't know if it's the tablets or what it is but the thing is, I'm feeling better.

There was still the concept of ‘problems stem from childhood’ in the form of conditioned behaviour, though this was linked with the above conceptualisation of it being ‘in the genes’

And I think I came from a worrying family. The way I'm conditioned, conditioned behaviour as a child. ...conditioned as a child and my dad was a worrier, worry, worry, worry, worry, worry. So that rubs onto you, you become conditioned and to be ...unfortunately. Sometimes I just wish I had a happy go lucky mum and dad but anyway, they were worriers and my mother did suffer from depression, so I've been told that that could be in the genes and that wee inkling. But I'm nothing like the way my mother is, she was actually quite ill for years with it. So, touch wood, I don't think, I'm not as bad as unfortunately she was.

7.1.4.3 Andrea's post-therapy resource / coping narratives

A further shift can be seen in the post-therapy narratives around resources and coping. The ‘coping and inner strength’ and ‘survival and getting through it’ narratives were now condensed into a single statement suggesting a more ‘altruistic sense of self’. Further, there was more emphasis placed on the use of ‘collective helping resources’ with a further theme of recognising the value of ‘following a pattern that worked’

Andrea appeared to have a more ‘altruistic sense of self’ which had merged the ‘coping and inner strength’ and ‘survival and getting through it’ narratives:

I believe there was a reason maybe why I got depressed. Because there was a, maybe there was a reason for me getting depressed, because it made me look at me. I found another bit of me. If I can feel that pain and survive it I can understand other people and maybe be a bit of help to them having that ear.

In comparison, the use of ‘collective helping resources’ had expanded to include Buddhism, the Quakers, and a lot clearer sense of the Catholic church being a resource:

Right it was a mixture of miscellaneous issue and it was the same getting out of it. It was a group of miscellaneous things to do, things to go. Aye, it was the same just, 50/50. things I go to, things to get out to. Try that, try that, try that. Try it all. Even went to the Quakers meetings around the corner. Marvellous. You paid a pound you got your lunch. And they were great. I mean, because I like food. So went to the Quakers meeting and these people are sitting there silence for half an hour, good reflective time, and then you go in and pay a pound and get a wee vegetarian meal. And have a wee natter. It's just I like meeting nice people. And nice people come usually with churches. Christianity, hill walking people are always nice people. People have got like minded. Right? It just makes me feel safe with nice people.

<i>And that was through the Buddhist centre and through Christianity as well. I mean I'm not saying this is the answer for everybody but for me I think the Christian side of thing has helped me as well and so whatever helps you, you go for don't you?</i>
<i>Well funnily enough I remember going to church and this minister I remember saying sometime you deliberately, sometime you actually become ill and maybe there's a reason why you're ill, as in depression or other illnesses, because maybe it's a time of reflection. Looking into your soul and because I take ill about every 15 years I pray like I've never prayed before and I, my faith, I go back to my faith.</i>
<i>Maybe I'm quite spiritual, maybe it's just me being spiritual but um. And I do tend to when I ...go back to church and I tend to pray and ask for guidance. I ask for guidance, where am I going in my life? What's happening to me? Show me the road? Help me? That's how bad you're feeling. What have I to do? Give me some guidance here because this life is absolutely (excuse me) shit.</i>

Here there was a new, much clearer narrative of ‘following a pattern that worked’:

<i>Following a pattern that worked. Yep. I just followed the same pattern for the stress because I was going through dreadful stress with the boy going through what he was going through.</i>
<i>...well let's think of all the things I've used before when I was going through this dreadful stress thing like when my son was fourteen and he was putting me through the mill. Didn't realize he had depression. I think they actually admitted him in treated him for anxiety and it was his psychiatrist who said it's not anxiety it's depression. Anti-depressants and eventually he got well. He came out and never looked back. And I used a centre I went to, I used to go to Time out but it's for people in Glasgow for depression. I went there. I went back to church. I used to find that helped. I did all the things that I done before that got me through it and it's worked. I repeated survival mechanisms and I've used here again, I've gone back to church, Time Out, I've actually weaned off Time Out. Don't need it. And that's a place to think. You don't have to, Christ you hang on until Wednesday night and you sit in groups and you go and what's you week been like and how's that and oh, that was a survival kit and thank goodness they had it. A lot of places don't have anything for depressive groups.</i>
<i>So I've just been through the same procedure but I did need crutches because I knew that sometime the immediate family are not the answer either because you're really needing somebody to be objective.</i>

7.1.4.4 Andrea's post-therapy change narratives

During the construction of the post-therapy LSM, Andrea spontaneously reflected on her memory of how things had been the last time she had been interviewed. The researcher also asked specific questions about what Andrea saw as having changed from her pre-therapy LSM. A number of key themes emerged which tell the story of recovery, and of how things had ‘got better’. These themes can be seen as relating a client's view of significant qualities of ‘outcome’. They included the view that ‘things are lighter’, and the sense of ‘coming to terms with and letting go of the past’. There was also a strong cognitive theme around ‘stopping negative thinking’ which seemed to be a significant aspect of change for Andrea. These themes are outlined using Andrea's words below.

Overall Andrea related that ‘things are lighter’, less heavy, and ‘fluffier’:

<i>Well I see brighter lights now in my life whereas before I felt quite trapped in my thinking and had a lot of pain and probably self blame that would come into my thinking which was part of the depression in my past.</i>
<i>Things are a lot more fluffier. You know I can see sort of light clouds.</i>
<i>And this isn't so heavy and weighed down, as I remember scribbling the last time</i>
<i>I see the future a bit brighter now. I just take each day now as it comes and when I go into a negative mode I know it's a load of rubbish and I just switch off and I don't let it drag me down.</i>

There was a strong narrative around focusing more on the present and ‘coming to terms with and letting go of the past’:

<i>But I feel I've come to terms with a lot of things, I actually feel I've come to terms with a lot of things and a lot of guilt was all in the mind to be honest with you, it was all totally unnecessary.</i>
<i>I've come to terms with a lot of things. The burden isn't there anymore because I've focused on that's life. Sink or swim...</i>
<i>Let go. It's gone. You know what I mean. The past is gone. Nothing that you do can bring it back or even change. You know you've got to live for the moment really haven't you? Tomorrow never comes. You just don't know what's round that corner do you?</i>

This sense of letting go was accompanied by a cognitive strand of ‘stopping negative thinking’:

<i>And that was my problem. I just became so negative in my thinking that I became addicted to it. That a day without negativity wasn't me. I had to keep tuning in to negativity. But now I feel there's a big space now, this big huge open space where I've had insight into the addiction of negativity. It's horrendous what this can do to your brain. So part of my counselling was to think of ten positive things each day and to alter my thinking. Because the brain is such a complicated unbelievable thing isn't it?</i>
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7.1.4.5 Andrea's post-therapy attribution narratives

Embedded within these change narratives were themes portraying what Andrea attributed the changes to. These themes have been constructed into ‘attribution’ narratives, telling the story of what Andrea thought caused the changes in her life. Perhaps the most prominent of these was that there had been a significant ‘reduction in external pressures’ which had relieved a lot of stress. Additionally, Andrea felt her ‘new medication’ has allowed a chemical rebalancing. There was clear acknowledgement that ‘counselling’ helped, specifically in terms of ‘being taught to think differently’. Significantly, this change in thinking seemed to also be attributed to ‘Buddhism’. ‘Exercise and getting out more’ was also attributed as a major cause for changes in mood. Finally, changes were also attributed to the passage of ‘time’. Following are details of each of these themes in Andrea's own words.

A ‘reduction in external pressures’ was attributed as key to feeling a lot better:

<i>a lot of problems have solved themselves within my life as in say circumstances regarding employment, incapacity benefit and all these things I had to fight and go through, and that's all solved. That's away, that's gone. Those stresses have gone because I won my appeal and that was satisfactory, because I'm a pensioner next year and it wasn't financially viable for me to go back to work because of the system because of my mortgage.</i>
<i>So that's been solved so I think once all that stress was taken off things lifted because unfortunately I think when I've got a lot of stress about me I tend to go into a mode where I think negative all the time. So a lot of that stuff about the external pressures, the mortgage...Gone.</i>
<i>But there was a lot of stress there, like financial stress and that's gone. And that problem was there also with my son, because I'd just bought a flat and the other son taking it on and I was working and I couldn't go to my work I was just so – aahh – so it slightly similar financial thing. But that's sorted.</i>

‘New medication’ and a rebalancing of chemicals was also seen as a cause of change:

<i>I'm on new medication as well which might have helped</i>
<i>So you take these anti-depressants that are supposed to replace all these right throughout the body. They just replace them right throughout the body as far as I know. The little that I know. Maybe the less you know the better. But I'm okay. Aye. Aye, I'm a lot better.</i>

This was also accompanied by a fairly strong narrative that ‘counselling’ helped:

<i>So I'm feeling a lot better now and the counselling has been, I mean she was good, she was very good</i>
<i>...just wanting somebody to talk to, to listen to you. Get it off your chest really because I don't really feel I've got that many folk to talk to about depression. My mum's dead, my dad's dead, my sister that's got a bit of depression herself she's not got any time for listening to you because she's too bothered worrying about herself.</i>
<i>Yes, an outsider that doesn't know you. To be obviously trained and they know what to do and what to say and how to handle the situation.</i>
<i>Counselling gave me focus. And it was a crutch. Just seeing somebody that has studied and knows a bit about the mind and, er, that was help... About the mind and how depression obviously affects people and where to give you a tissue because you're...</i>
<i>They {the counsellor} know what you're talking about. They can understand, decipher why you're talking really a lot of gibberish at the time when your depression is quite heavy. They know why you're being that way through their study and maybe a lot of counsellors have actually had depression.</i>
<i>Maybe there's a link there, a common denominator there. Maybe they've been there, done it, and know where you're coming from... There's a comfort. It's like, they know. You're okay. You're not alone.</i>
<i>Private and confidentiality on a one to one basis with someone who has studied the mind and studied peoples reactions to life. It was just time, because you've got an hour. You go to your doctors you've got 5 minutes. Time.</i>
<i>Relax. Or whatever you're feeling at the time. You don't get that anywhere else apart from counselling. You'll not get it with your GP, he hasn't got the time to do this. He's on all day so many people see him it's all 5 minutes time. So you don't have the time with your GP so really counselling is the next step isn't it.</i>

Specifically, 'being taught to think differently' seemed to have been attributed as a major source of change and this came from both counselling and 'Buddhism':

<i>I couldn't seem to get out of that mode until I starting thinking about a bit of counselling ...write a hundred things that you like about yourself you know. I thought that was really hard I thought aah a hundred things that you like about yourself. That was just to get the brain turned into another gear isn't it. Go into that gear and into that gear because the brain has went that way.</i>
<i>I've actually been going to the Buddhist centre and their meditation is very good and their thinking is very good and it really puts everything to me into perspective... I met one of the monks at the Buddhist centre and I found that he had a brilliant tape that one of the guys gave me to listen to. And he was addicted to negativity. He was so negative it became an addiction.</i>
<i>That negative thinking, that depressive. Dreadful. I mean the human brain. That's what you'll be studying the human mind or some of it. How it works. How you could do it if you kept thinking negative all the time that's the way you're thinking and you'll never get out of that unless someone takes you and teaches you to stop thinking that way and go that way.</i>

A further significant cause of change was put down to 'exercise and getting out more':

<i>I mean I can go back to the hill-walking I mean I can get my endorphins going with the hill-walking I can get my highs out of that I suppose right enough. Which is very good, exercise is very good but I usually do dancing now to increase the energy sort of thing. I will get back to doing the odd rambling sort of thing you know because it does make you feel a lot lot better. Shoving yourself, getting yourself out of that door and go for it and exercise.</i>
<i>Meeting people, talking to people when you go out because it's actually a club I belong to so there is quite a wee crowd of people turn up for these walks you know. It's not as if I do it on my own, which I wouldn't do anyway. Not as a female on my own. So it's good, so it's really do sort out that wee bit of chemical imbalance get balanced your whole thinking is really the way it used to be when you were feeling okay. Oh good I'll go back to my...oh that's great.</i>

Andrea also felt that 'time' was a significant part of her change process, in combination with the other support:

<i>How did I get out of it? Now there's a question. Time... Time. Medication. Help. Support.</i>
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And you know it takes time. I think you've just got to go through the whole motion of going to support groups, doing what you feel up here that helps...

And time fixes it. And then you're back on the road. It takes, and it takes time. And you can't rush it. It's something you can't rush. It's, it'll happen when it's ready I feel.

7.1.5 Andrea's follow-up Life Space Map interview

Approximately 6 months after the end of therapy, Andrea was invited back for a follow-up interview where she once again completed the CORE-OM questionnaire and constructed a Life Space Map. The LSM took approximately 50 minutes to complete, significantly longer than her post-therapy LSM (20 minutes), and about the same duration as the pre-therapy LSM (55 minutes).

The process started with the researcher again introducing the task: *"Like last time, just to put down on paper a rough picture of how you see your life just at the moment, the significant things in your life. Again, what I'm going to be doing is afterwards comparing this with what you put down before."* Andrea was clearly more agitated in the process of constructing her follow-up LSM, beginning the process with *"Well, I've picked red because I think I still feel a bit, um, at the moment. I think I was feeling better the last time I saw you. I think at the moment I feel more agitated..."* There were times that Andrea struggled a bit to represent what she was discussing on the LSM: *"Kind of making sure everything is in its place. So right and make sure that's dead square and... I don't know... I really don't know how to draw that..."*. As with the previous interviews, the researcher empathically reflected back to Andrea (e.g. *"Making sure everything's just so..."*) as well as conjectured empathically about additional meaning (e.g. *"Like an anxiousness?"*).

From the beginning, it was clear that Andrea was aware that things were not going as well as when she had finished therapy. After completing her follow-up LSM, Andrea further commented on this saying *"I think it's slightly better than the first one from what I can remember. Don't know if it's slightly worse than the last one"*. Following this, Andrea was shown both her pre-therapy and post-therapy Life Space Maps and asked to reflect on the differences she saw between them all. At the end of this process, Andrea was again asked about her experience of using the different methods and of being part of the research study in general.

7.1.6 Andrea's follow-up narratives

As with the post-therapy interview, the themes of 1) Problem narratives, 2) Causal narratives, 3) Resource / coping narratives, 4) Change narratives, and 5) Attribution narratives have been used to organise Andrea's words.



Figure 7-3 Andrea's follow-up Life Space Map

7.1.6.1 Andrea's follow-up problem narratives

Interestingly, the themes of 'repeated adult trauma and hurdles in life' and 'unfinished business with ex-husband' almost seemed to have disappeared, with only passing reference to them. Similarly, the theme of feeling 'relationally scarred' was again absent. The feeling of 'depression' had definitely become more significant, and the reference to 'OCD' as being a problem had returned and was now tentatively linked to the feelings of 'guilt / self blame'. The theme of feeling 'abandoned / lost / empty' had returned accompanied by a strong sense of 'loneliness / disillusionment'. The broader references to 'the world's a mess' and the pragmatic issues around 'alcohol' from the post-therapy interview were no longer evident.

The themes of 'repeated adult trauma and hurdles in life' and 'unfinished business with ex-husband' were even more resolved than at post-therapy interview:

The regrets maybe about the marriage. Maybe it's a pity the marriage hasn't worked. It's a pity my daughter was brain damaged at birth. That kind of contributed to the marriage breaking down. And then you say to yourself, well, happens to us all. Look at all these folk that have got worse disasters than that, you know what I mean? You've got to sort of, I know it's bad to think negative defeat. To feed some positive into your life, you know, there are folk that lose their kids and all that. It could have been worse and that's fine.

'Depression' had returned as a more significant problem than at post-therapy, particularly in relation to the reappearance of 'OCD':

Is the depression worse? I think it is a wee bit worse.

But it's because I've got the depression you see. If you didn't have depression you wouldn't be thinking this way. You think, god I hope this doesn't get worse. Imagine being really, really, really, really, excessive depression.

I mean, I've got depression but it's not just that because I had depression on and off, very mild, maybe it's a wee bit worse just now and I think what I've got just now is a touch of OCD. You know. Checking things and becoming a wee bit like that. I hope that doesn't get any worse.

I mean it's probably because I don't want to harm anybody or anybody getting harmed...I don't know. Did I put that cigarette out? Do you know what I mean? Did I put that cigarette out? And you're like this. And you know it's out. Are you with me? But you keep going like this. It's out.

You're aware. You know it's out and at the back of your mind, you don't want a fire, or you don't want to hurt anybody. You make sure that's out.

Today I was at the town centre, in the toilet, nae bother in there. Toilet, out, checking the taps off. Another wee bit of OCD. You bloody know the taps off but you do it because you don't want the tap to be left on and the toilets getting flooded... What a load of crap. You know.

Linked to these references of 'OCD' was a renewed sense of 'guilt / self blame', though this was only explicitly referred to once:

Probably there is an anxiety thing. Maybe I feel that often you don't want to feel guilty. Maybe it's a feeling of guilt, of anxiety. Maybe that's too strong a word. Maybe you just want to feel perfect. Maybe I am perfect. That'd be great to be perfect... Maybe it is reaching for that perfection. Maybe it's a bit of a perfectionist... They can be a bit like that can't they? Kind of making sure everything is in its place. So right and make sure that's dead square and... I don't know...

The feelings of being 'abandoned / lost / empty' seemed to have magnified and had an added quality of 'loneliness / disillusionment':

<i>I suppose I'm also getting a bit lonely. I never met this Mr. Wonderful that I don't think exists. At the end of the day either I've not been fortunate or I'm so independent now...</i>
<i>That wee bit of security. Even if it's psychological. Just that person to confide in, and you think they're taking care of you, whatever, you know. I really don't like being on my own and thinking 'this is it'.</i>
<i>It's just, it's the loneliness, it makes me scared... This emptiness. I mean, where am I getting all this fear of 'on my own'? There's a fear there. Its actually a, not all the time, just sometime I'm sitting in my wee flat and you sit and you go, you've got your wee telly, you've got your fire, you've got your food, you've got your warmth, I'm not coming to any harm.</i>
<i>I suppose there's this kind of emptiness and you know. And I'm sitting maybe prematurely thinking, forward planning here, when I put my name down for sheltered housing. Which is dreadful isn't it?... I'm empty. If this is going to be me I'd rather die in my sleep. I know that's kind of defeatist isn't it? And negative. It's how you...you know what I mean?</i>
<i>And I'm thinking to myself even folk that have got husbands have still got somebody they can go home to I'm feeling sorry for me because I've got nobody. Right, there's a wee bit of, Christ there's some folk that land in it, land right on their feet and I know that sounds horrible because I'm feeling lonely and I've not got anybody to go home to.</i>
<i>But they're coming out but going home to their men and I'm going home to an empty house and I'm feeling ugh. That's not nice. But that's how I'm feeling. That's how I'm feeling...It's like a nasty, poison. A poison in your system. It's horrible.</i>
<i>It's not enough... What a horrible life. Really. I mean that's my thinking. I know some folk are deliriously happy because they're on their own. And wouldn't have it any other way. I mean I don't think I would have a man move in. But it would be nice to know I could say 'hello Jimmy, I'll just come round for a wee visit tonight. What are you doing?'</i>
<i>I just feel, it's poor me. I'm thinking to me, poor me, poor me I mean she's got a boy with her. And it's just because I'm feeling that bit more isolated.</i>

7.1.6.2 Andrea's follow-up causal narratives

The follow-up causal narratives of 'depression as an illness' and 'problems stem from childhood' were again apparent, as was the idea of 'problems in thinking' being a cause for Andrea's situation. While the 'powerlessness' and 'Catholic Church as the source of guilt / injustice / anger' themes from the pre-therapy interview were still not present, the 'social isolation' narrative had strongly returned after an absence in the post-therapy interview.

The theme of 'depression as an illness' was still a very dominant theme which affected everything else and needed to be controlled with medication:

<i>But it's because I've got the depression you see. If you didn't have depression you wouldn't be thinking this way. You think, god I hope this doesn't get worse. Imagine being really really really really, excessive depression.</i>
<i>Maybe it's ready to grow. Maybe it's going to get worse... Because my mother was like that you see. It's my mother. You're thinking "I hope I don't finish up like my mother".</i>
<i>And I don't know, you don't know much about medication do you?... because there's hundreds of them right enough. How do these doctors know what to give you? I mean it's really the luck of the draw isn't it? Try that one (laughs). Because the medication can make you or break you. I mean the medication ...It's getting those endorphins right. It's getting that chemical imbalance to be a bit better than what it is when depression sets in. You know.</i>

There was also still evidence of seeing that 'problems stem from childhood', in particular to do with OCD:

<i>...and I don't know whether it comes from childhood or whatever... Maybe it's because I was brought up with my dad constantly checking switches and watching that. Just going to check the house, and checking 3 times. So maybe it's a learned behaviour. As a young child you're learning behaviour. You're watching this and maybe something, I don't know, is in there.</i>
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The theme of 'problems in thinking' seemed to have become more prominent, especially in relation to OCD, though this was also seen as a chemical imbalance and as 'in the genes':

Oh very aware of your thoughts and how do you get those compulsive thinking things out of your mind when you know it's a load of crap? Why do you think that way? Is it because it's a chemical imbalance? Or is there... Where's it coming from? Where is it coming from? Why am I worried about that? Why am I like this? Wouldn't wish it on my worst enemy. You know what I mean?

I can see into it. I can see it and I go why? And other times when you've got it and you keep trying to get it out of your head. And you come to reason with it and you know it's, it's pathetic. And then, you know what I mean, why am I doing that? It's just. I think it's in the genes. I don't know if it's in the genes or if it's. I don't know...

Even stronger than the pre-therapy interview, Andrea related her 'social isolation' as a dominant cause for her current problems, particularly her feelings of loneliness.

I'm lacking in contact. Maybe not just with men, maybe with females as well. I haven't really maybe opened up a lot and told a lot of folk my problem and maybe I haven't confided in a lot of people that I've got depression.

And I think that's because, because I'm not going out as much as I used to. You know what I mean. I mean I used to go out and when I had the depression I was being distracted. I was out, I wasn't thinking about things that are full of crap, because you're out, you're being distracted. Instead of that, I'm sitting in. And they're all coming out, things are all coming out of your active mind. You're sitting like that and you're, I know I'm doing it. And I'm going oohh, oh Andrea

What I have to do is get out more. Become involved and not go 'oh I can't go there and I can't go there', because I'm actually shutting myself off from what is help and normal functioning of being out and associating with people like I used to do. And I think my life's still from years ago from when I used to go out all the time doing this, dah dah dah, I was happy, I was occupied, I was busy, I was functioning. Now I'm kind of going into myself a wee bit and for me that isn't healthy.

Because I don't have a boyfriend, don't have a relationship. I'm not going to the disco scene in the night where I used to go. Lots of dance halls have shut down. Lots of the singles clubs have shut down, so I'm becoming more and more isolated. I'm becoming quite aware of that.

7.1.6.3 Andrea's follow-up resource / coping narratives

Significantly, the post-therapy resource / coping narratives around 'altruistic sense of self', 'collective helping resources' and 'following a pattern that worked' all seemed to have disappeared. There was no sense of having a list of resources that could be used to help. The previous strong narratives around spirituality as a resource including the Catholic Church, the Quakers, and Buddhism were absent. There were a couple of references to the GP as a resource, but all the others had disappeared. This may have been connected with the sense of 'social isolation' that Andrea expressed. There were some 'thin' narratives around 'coping and inner strength' and 'survival and getting through it', but these looked to have become more of an 'inner critic' than a resource. Interestingly, there was a new sense of having being 'an actress playing a part' as a form of coping.

The themes of 'coping and inner strength' and 'survival and getting through it' seemed to have shifted towards being more of a harsh 'inner critic':

I do feel okay a lot of the time, I'm fine. And it's really just lack of distraction, and coping mechanisms with your thoughts which can be quite difficult at times. You know. It's a lot of imaginary crap that makes you depressed. A lot of imaginary absolute crap. And how does your brain think of all that.

It's not enough, to think that I could be sitting in 7 nights a week if I didn't give myself a kick up the backside. What a thought. You know what I mean? It's as well putting yourself in a coffin and putting a lid on it. Really. You've got to do it for yourself. Nobody is going to come to your door and take your hand and go 'come on, I'll take you to this social club'. 'Oh thanks very much.' This is the difficult bit. And I've always managed to do it on my own. I've always managed it.

Maybe you're feeling a wee bit sorry for yourself. Let's be honest. Maybe poor me. Get a grip Andrea. I'd be saying to somebody 'get a grip, get out there'. I'd be telling them to do what I'm not so good at doing as I used to be. Get a life. Nobody is going to come to your door and if you want to go on you've got two choices, you either sink or you swim. What do you want to do? Do you want to swim? Do something about it. Right. You can go there, there, there, there, there, okay.

And I'm a wee bit kind of maybe, crabby. And I think it's because I'm just not bloody happy with my lot at the moment. And that's it. I'm not happy with my lot right. So if you're not happy with your lot I have to make changes. I have to make changes.

The theme of being ‘an actress playing a part’ potentially related a coping strategy from the past. This though seemed to be ‘wearing thin’:

Nobody knows I've got depression, at the ...club. They wouldn't even dream I've got depression because I'm a good actress. 'Life is so fantastic, brilliant'. I go home, shut my door 'oh my god' (laughs). It's the acting... I should have been at drama school. I might even go to drama classes actually for the 50+ at [college]. I think they might run something. Because I think I would maybe get an Oscar.

Because people only know me as Andrea, ah smashing person. Takes everything in her stride and obviously I'm preserving my, my person that people know. As a nice person rather than go 'see that Andrea, oh she's a bit'. You know, you want to remain that person that they think you are. And I've been able to keep it, there's only been certain occasions and I would say I would justify myself...

7.1.6.4 Andrea's follow-up change narratives

Similar to the post-therapy interview, during the construction of the follow-up LSM Andrea noted on several occasions how she had felt things had changed. It was apparent from the beginning of the interview that things were not as good as they were before. The researcher also asked specifically about changes towards the end of the interview after showing Andrea her first two LSMs. The previous theme of ‘things are lighter’ was no longer evident at all. The theme of ‘coming to terms with and letting go of the past’ was mentioned briefly in terms of not being able to do this. Similarly, the previously strong cognitive theme around ‘stopping negative thinking’ seemed to have lapsed. A very prominent theme of having become ‘more irritated / intolerant / annoyed’ was evident throughout the interview. This was connected with more positive change narratives around a feeling of having ‘a right to speak out’ and a sense of ‘growing older and wiser’.

The theme of ‘letting go of the past’ was mentioned briefly in terms of not being able to:

Why am I hanging on to this aggravation whereas 'let it go'... It's hanging around because I think I really feel it's unfinished business. That I'd like to get a hold of her. You know, face to face, nothing violent.

The most dominant change theme throughout the interview was around feeling ‘more irritated / intolerant / annoyed’:

So, um, just a wee bit more irritable and I can't be bothered with moany faced people. Funny, I've never, I've always been able to sit and listen to people talking about people and saying see her and see him and I wouldn't comment and would just sit and listen to them and go 'och well, none of us are perfect I suppose' and be quite placid and laid back.

So that annoyed me. That really, really annoyed me. Somebody pushing, somebody sort of justifying herself for her behaviour, you know, sitting there talking to someone the other side of her. 'Oh it must be great to be perfect', meaning me, because I had got her. 'It must be great to be perfect, it must really be great to be perfect.' And I'm going 'is that me you're talking about?'

That annoys me. That just fucking annoys (excuse me). That aggravates me, you know what I mean? Look at yourself, look at you. But anyway that was just something that really, really... So obviously she's not really a suitable person for me to go about with if she's going to be like that anyway. Because I don't like folk talking about folk and especially running people down, er, all the time. I mean, I was going out with her to have a wee dance, couple of drinks, socialize and I'm getting nip, nip, nip, nip, nip, in my ear. In my face.

But the unfortunate thing with that is the one sort of male friend I've got, it'd be him I'd be going with and he's another one that gets on your nerves. He's getting on my nerves more because he knows he's irritating. He'll even say 'I know I'm irritating'. And when I was, I mean I've known this guy 13 years but he's only a friend and he's a batchelor and he's got a house like a tip.

He annoys me, I've actually went for him. Scratching. That's not me. I'm not like that. He's got me to the stage I'm at frenzy. And he said 'you should see your face'. I said that's you that's causing that face, you! ... See the anger, see the anger... So really maybe I'm better shot of him.

Maybe I'm better not with that friendship. 12 years and he still hasn't got that house tidied up. Now, there's only so much you can take.

This irritation was connected with a more positive change narrative around Andrea feeling she had 'a right to speak out' and wouldn't be silenced anymore:

It's because you speak up for yourself. Some folk don't like it... Especially when they're used to me just being so laid back and 'I can say it to Andrea, she's a laugh'. And you know, and sometimes I think I'm feeling that I take it so much now and I feel that if it's really annoyed me I'm going to come out and say something.

I think I've been justified in when I do come in and say something because at the end of the day I'm getting to the stage where life's too short, I've suffered it so long and I come in and speak my piece. I don't care. Say my piece. So maybe that's just experience or whatever. Maybe sometimes I don't say it the way I would like to say it, more flowery

I feel actually I've got a right. I don't actually just out of the blue come out and go uh! It's been analysed and I take it, and I take it... And then I feel, 'Wait a minute. Something needs to be said here'... I feel quite assertive but I feel it's a self preservation that could cost you friends... It could cost you maybe your reputation. Easygoing Andrea? You want to bet son, you give me too much of that and I'm going to come in and say something.

These themes were also linked to a sense of 'growing older and wiser':

Maybe I'm getting older and wiser and maybe the people that have annoyed me that I've let annoy me for years maybe I would maybe go and say 'can I have a wee word with you please?' Okay. Just to cut it. 'I'm not stupid and as daft as you think I am. I'm watching and listening to everything that everybody, right okay?' You know... Maybe, maybe it's getting back at, do you think I'm stupid? I know I'm placid but do you think I'm absolutely daft? Like an anger. Maybe there's a lot of anger there in my system, and then when I feel justified to say something maybe I'll come out with it.

But I'm really outgrowing the things that I've done... I'm looking at life differently... The thought of going down to the bowling club at night. Seeing the same old faces every Saturday night. All pissed out their box. And all jumping about the dance floor really doesn't appeal to me anymore. And I was one of those ladies that used to jump about that dance floor... Now, I look and I go 'god that used to be me'. I enjoyed it at the time but I look at it now and I feel as if I've outgrown that kind of... For god's sake. What are you doing. Getting pissed and acting like a young one. And I was doing that a few years ago, you know what I mean? And that was me 58, acting like a 25.

And I think I'm just changing maybe. Not just with the depression maybe I'm just getting a wee bit older. Maybe a wee bit wiser... And now I'm sitting back and only watching and going 'that used to be me'. And how, how stupid do they look. But then again, who was caring anyway, because you were having fun. You know. And I would never say to them it's just I'm thinking 'god, that's how I used to look'. Right. Fair enough. I was happy. I was enjoying myself. But, do I really want to do that now?

7.1.6.5 Andrea's follow-up attribution narratives

Though not as explicit as in the post-therapy interview, Andrea related a number of attribution narratives as a way of explaining these changes. Though the 'reduction in external pressures' had largely continued, there were signs of increased financial concerns. Additionally, there was some indication that her 'new medication' may not be working as well as before. There was still acknowledgement that 'counselling helps', specifically in terms of 'being taught to think differently'. 'Exercise and getting out more' was mentioned in terms of something that had lapsed and needed to be done again. However, probably the biggest single attribution of change during the interview was 'time', specifically in terms of getting older. The following give a flavour of these themes in Andrea's own words.

The previous 'reduction in external pressures' seemed to have been largely maintained, except for a return of some financial concerns:

I'm sort of running out of cash... At one time money wasn't a problem. I could go out, that's how I could go out more, I had the money. Are you with me? I had the money. Now I'm looking at this singles club I'm in £14 for a meal. That might be cheap to you, that used to be cheap to me. Now I'm going 'now for £14 I could get, I could get 3 meals out of Wetherspoons for that'. If I pay £14, so in doing, not going to that, I'm cutting myself off from meeting new people in this club, maybe making a few new friends out of it because I'm not going. So, money is a wee bit of a thing at the moment. I'm kind of watching my money. Because when you've got money, you've got some money to do, 'ah book me in for that meal'. So you're going out more. I when you're watching your, you're going £14. I could do me 3 meals in Wetherspoons. 2 for £6, 2 for £7...

I need to do something about it and I know that. And to hell with the money. I'll get there somehow. I think that the money factor subconsciously I wasn't realising that I wasn't maybe going to the band night and I wasn't, I was avoiding places, unwilling to make the time. But these are places where you've got the opportunity of meeting new faces, meeting new people and I've been cutting them off...

Andrea seemed to relate that the 'new medication' she was on was not working as well as it had:

You know, I kind of, feel a bit agitated and I don't know whether that's to do with my medication, which I'll see my GP about next week...

Something's not quite right. Something's not quite right. I'm not my bubbly self. Er, I'm okay, I can still, I mean I can go down tomorrow to the bowling and I'll be um, but this medication's making me feel a bit giddy. A bit light headed. And a bit kind of compulsive. You know sort of washing your hands and maybe. And I know I'm doing it. What do I do that for? It's a kind of thing like it was on the TV and I saw a woman going it was about not wanting to hurt anybody so you're washing your hands but they're not dirty, before you touch food. And this, where it comes from I think they reckon it's childhood, I don't know where it comes from. But this OCD thing and there are certain SRIs, certain types of anti depressants.. och, I'll see my doctor about that...

The theme of 'counselling helps' and 'being taught to think differently' was still evident, though interestingly this was largely around Andrea's OCD:

<i>The only way you can do that {take away the depression} is with therapy or medication, or both. Or cognitive behavioural therapy that tends to work with OCD.</i>
<i>But it's a behaviour that can get worse unless you're willing to cut it dead... cognitive behaviour {therapy}, whatever it's called. It's off, walk away. Starting to, it's off, walk away. Working at it that way, to save getting into this scrambled brain... Scrambled brain, and you know it. It's a horrible, horrible illness that. And I've got a wee touch of it I would say.</i>
<i>And you want somebody just to come up and going to wash that bit of my brain away with a hose. Take that area away because this is absolute nonsense.</i>

Andrea related that ‘exercise and getting out more’ had been something that had worked in the past but which she had ‘let go’ of a bit and could no longer find the energy for:

<i>I've not got enough to do, I've let myself go a wee bit with the depression. When I was younger, I mean I had depression, slight depression when I was younger I'd more fight, more go. Right I'll go to night school, do that. Must go there. Now I'm sort of going, what do I do?</i>
<i>And I'm finding myself a wee bit tired and lethargic to go out. Whereas before I'd go right. You see I'll have to get back to the hill-walking. I have to do all these things. Up hills and because I've been away from it for such a long time but would I need to do is one Friday night get the boots out, get them polished, get the rucksack, get the flask, get the sandwiches and go right. And no excuse. Get the coat and go. You know what I mean? I've sort of lost that wee bit of get up a go.</i>
<i>I used to be, right, up at 7. I know what is the syllabus. I know where I'm meeting them. I know where I'm going. And you do feel much better for it. I know exercise is one of the best things isn't it for [depression]. It just lifts your spirit and lifts you. You're distracted again aren't you, talking to folk. Instead of that sitting in like a wee old woman with a shawl. I said 'oh my god, I'll have to do something'. So I couldn't, my effort's not quite as there. It's a bit. And I know I'm doing it, I'm going oh, can't be bothered.</i>

One of the most significant attributions of change in the follow-up interview was ‘time’, specifically in terms of getting older. This seemed to be both positive and negative:

<i>Or whether it's just the stage I'm at in my life, getting older and probably the fact I'm feeling quite intolerant to a lot of things. Whether that's because you're older and wiser and what you could put up with sometime ago, you know, cut to the chase, folk go on too long about certain things and I could, wish they would hurry up and get there...</i>
<i>I think it's, you know, the fact that years ago I was more patient. And the people and now I'm at the stage where, I call it self preservation, in situations I get into. And if someone is really annoying me and doing things that I think are out of place, rather than before saying nothing and just take it, I'll come in with verbal comments, to get them out of my face.</i>
<i>But um, maybe this is just how you say grumpy old bugger, to folk. Grumpy old man or grumpy old woman because maybe folk do get older and become grumpier anyway..</i>
<i>And maybe, I don't know, maybe it's an age thing as well... When they talk about grumpy old men. Because I mean you get older don't you and get more ailments and life's passing you by really. You know you're in the last quarter of your life or whatever and maybe you're life isn't going... the way you liked it. But I mean that happens to everybody doesn't it? I suppose it happens at any age but I think more so as you get older.</i>
<i>I think the age thing has quite a bit to do with it. I think. I think I did most things in my life in a way that I wanted. I had a lot of ache, a lot of pain, some regrets. I think on the whole I've had my fair share of disappointments, but I've had my fair share of luck as well.</i>
<i>I think personally, I'm now coming to 60. I'm not a wee lassy anymore. I'm not even a young woman anymore and I will always give time, say I'm sorry if ever I say anything that's offended somebody and then when it goes on and on and on and on. And I'm maybe feeling a bit, maybe jealous of the other person.</i>

7.1.7 Summary of Andrea’s narratives

The above narratives have been summarised into the tables below and rated using the levels of narrative extensiveness and significance as detailed in the Method (see Section 6.6.1.2). These

levels can be seen as roughly equivalent to the CORE-OM severity levels and provide a way of seeing changes over the different interview stages of therapy, with darker shades/higher numbers indicating more extensiveness/significance than lighter shades/lower numbers.

7.1.7.1 Summary of Andrea’s problem narratives

Andrea’s problem narratives can be seen to shift from being focused mainly on past situations related to repeated adult trauma, unfinished business with her ex-husband, and feelings of being abandoned and of guilt, to a point of resolution and relative contentment, then to focusing more on present concerns around her current loneliness and feeling empty and lost with respect to the future. There is also a change from a focus on depression as the main problem with OCD being secondary, to a relatively ‘managed’ view of depression, then to a situation where OCD has become more prevalent with depression slightly secondary. During the middle phase of these shifts, it is as if Andrea has more mental capacity to reflect on other broader and more pragmatic issues, with the reference to more worldly issues and her use of alcohol, which disappear again at the follow-up stage when her personal problems seem to take centre stage.

Problems:	Pre-therapy	Post-therapy	Follow-up
Repeated adult trauma and hurdles in life	Dominant, most prevalent theme (4)	Present but more ‘processed’ (2)	Present but even more ‘processed’ (1)
Unfinished business with the ex-husband	Significant problem theme (4)	Present but more ‘forgiving’ (2)	Present but even more ‘processed’ (1)
Relationally scarred	Moderately present (3)	Clearly absent	Clearly absent
Abandoned / lost / empty	Moderately present (3)	Clearly absent	Now more prominent than pre-therapy (4)
Loneliness / disillusionment			New and strongly linked to above (4)
Guilt / self blame	Moderately present (3)	Still present but ‘reflective’ (1)	Still present and now linked to OCD (1)
Depression	Present and highly significant (4)	Still present but ‘managed’ (1)	Present and more prominent (2)
OCD	Briefly present (2)	Clearly absent	Significantly more prominent (3)
The world’s a mess		New ‘broad’ problem (2)	Clearly absent
Alcohol		New ‘pragmatic’ problem (1)	Clearly absent
Total (Mean)	23 (3.3)	9 (1.5)	16 (2.3)

Table 7-1 Summary of Andrea's problem narratives

7.1.7.2 Summary of Andrea’s causation narratives

Andrea clearly sees depression as an illness which needs to be treated, and this is maintained throughout the different stages. However, it can be seen that this initial ‘storyline’ becomes more differentiated as time progresses, with the emergence of much stronger sub themes of depression being genetically linked, and being around problems in thinking. Of particular note, the social isolation narrative having disappeared altogether at the end of therapy becomes most prominent at the follow-up stage. There would seem to be a direct link here with Andrea’s ‘loneliness / disillusionment’ problem narrative emerging at this follow-up stage. Interestingly, the narratives

around powerlessness and issues with the Catholic Church which feature quite strongly at the pre-therapy stage seem to no longer be relevant later on. This could suggest a shift towards more personal empowerment, which may be reflected in the significance of the narrative around childhood steadily diminishing as time progresses.

Causes:	Pre-therapy	Post-therapy	Follow-up
Depression is an illness	Clearly dominant theme (4)	Still present but more accepting (2)	Still present (2)
It's in the genes		Emerged as cause depression (1)	Similar to post-therapy (1)
Problems in thinking		New cause of problems (1)	More prominent than post-therapy (2)
Problems stem from childhood	Prominent but secondary theme (3)	Still present but reduced (2)	Still present, esp. regarding OCD (1)
Social isolation	Briefly present (2)	Clearly absent	More prominent than pre-therapy (3)
Powerlessness	Briefly present (2)	Clearly absent	Still absent
Catholic Church as the source of guilt / injustice	Prominent cause of feelings (3)	Clearly absent	Still absent

Table 7-2 Summary of Andrea's causation narratives

7.1.7.3 Summary of Andrea's resource / coping narratives

The story of Andrea's pattern of coping / resources reveals a shift from a central focus on inner strength and 'getting through it' at pre-therapy, to using more external resources at the post-therapy stage. At this stage, there is a sense of a rich support system that Andrea knows will work for her. Significantly, at follow-up this reference to a support system has disappeared, which would seem to directly relate to the loneliness problem narrative and social isolation causation narrative above. Further, the previous strong inner support seems to take on a more 'inner critic' narrative. This is perhaps corroborated in the emergence at follow-up of a reflective narrative around having previously 'played a part', of pretending to be more 'capable' than she actually was. This is an interesting shift, and potentially reveals a growing insight and dissatisfaction with past coping methods.

Resources	Pre-therapy	Post-therapy	Follow-up
Coping and inner strength	Dominant resource narrative (4)	Present but minimal (1)	Present but minimal (1)
Survival and getting through it	Secondary resource narrative (3)	Present but minimal (1)	Present but minimal (1)
Inner critic			Previous 'strength' now more critic (4)
Altruistic sense of self		New but only briefly present (2)	Clearly absent
Collective helping resources	Briefly mentioned list of resources (2)	Present and even more extensive (4)	Clearly absent
Following a pattern that worked		Emerges as a linked to above (3)	Clearly absent
An actress playing a part			New relating of past coping method (2)

Table 7-3 Summary of Andrea's resource / coping narratives

7.1.7.4 Summary of Andrea's change narratives

There is a dramatic shift in Andrea's change narratives from the post-therapy stage to six months later at follow-up. The clear narrative of feeling lighter and having let go of things after therapy is only minimally apparent at the follow-up stage. Similarly, the strong post-therapy focus on stopping negative thinking is absent at the later stage. Instead there is a very strong narrative around being more irritated, intolerant and annoyed. Though this has a distinctly 'negative' flavour to it, this is associated with a narrative around having more of a right to speak out, and of growing older and wiser, getting too old to 'play the game'. This seems to have a direct link to the coping narrative of being 'an actress playing a part' above, and corroborates the suggestion of growing insight and dissatisfaction with past coping methods. Conceptually, this could be seen as a positive therapeutic shift with a greater dissonance between Andrea's self concept and her experiencing/organismic self resulting in more agitation. This agitation would ideally lead to a further shift such that the self concept is more aligned with the experiencing/organismic self.

Changes	Post-therapy	Follow-up
Things are lighter	Overall sense of change (3)	Clearly absent
Coming to terms with and letting go of the past	Focusing more on the present than the past (3)	Only minimally present (1)
Stopping negative thinking	A key reason for feeling better (3)	Clearly absent
More irritated / intolerant / annoyed		Major new more negative change (4)
A right to speak out		New positive change of gaining a voice (3)
Growing older and wiser		New positive change of 'growing up' (3)

Table 7-4 Summary of Andrea's change narratives

7.1.7.5 Summary of Andrea's attribution narratives

Of particular interest to the present study is Andrea's relating of the attributions of the changes that have occurred for her at the post-therapy stage. While counselling had a significant part to play, this was clearly in association with many other factors. There is strong reference to external pressures which seem to have been a major reason for Andrea's initial turmoil, even though these were not specifically referred to at the pre-therapy interview. Medication has also been a factor in the changes, with Andrea being prescribed new medication during the course of therapy. The use of other resources such as Buddhism and exercise has also clearly contributed to the positive changes that Andrea experienced at the end of therapy. Significantly, all these factors were only minimally or briefly referred to at the follow-up stage, or not mentioned at all. The one persistent theme which is present at post-therapy and significantly more prominent at follow-up is time. In particular, the growing sense of getting older, of time moving on and 'running out', seems to be a predominant factor relating to Andrea's change narratives around having a right to speak out, of growing wiser and less tolerant of other people imposing themselves on her.

Attributions	Post-therapy	Follow-up
Reduction in external pressures	Most significant cause of change (4)	Briefly related as cause for things getting worse (2)
New medication	Possible cause of change (2)	Feeling more agitated now on medication (2)
Counselling	Also seen as major cause of change (4)	Only passing reference to CBT (1)
Being taught to think differently	Most important aspect of therapy (3)	Mainly related around problems of OCD (2)
Buddhism	Also contributed to changed thinking (2)	Clearly absent
Exercise and getting out more	Significant reason for feeling better (3)	Related as not doing enough of this (2)
Time	Time combined with all the above (3)	Major cause of changes in terms of getting older (5)

Table 7-5 Summary of Andrea's attribution narratives

7.1.8 Andrea's CORE-OM changes

As a comparison to the above qualitative description of change, following is a brief summary of the quantitative changes that Andrea noted on her CORE-OM form. Using the new CORE-OM scoring system (see Section 6.6.2 for details) Andrea's pre-therapy clinical score was 15.59 (Wellbeing=17.50, Problems=20.00, Functioning=16.67, and Risk=3.33). At post-therapy, Andrea's CORE-OM score had dropped into the non clinical range at 8.82 (Wellbeing=15.00, Problems=10.00, Functioning=9.17, and Risk=1.67). This level of change demonstrates both clinical significance (the overall score has dropped below the clinical cut off point of 10) and statistical reliability as the magnitude of change (6.77) exceeded the recommended reliable change index (RCI) of 5 points. At the six month follow-up, there is some evidence of 'relapse' as the total CORE-OM score has just returned to the clinical level of 10.61 (Wellbeing=17.50, Problems=10.00, Functioning=12.73, Risk=3.33), though this is not statistically reliable as the change of 1.79 does not exceed the RCI of 5.

These figures are represented visually in the graph (Figure 7-4) below. Note that the clinical cut off score of 10 only applies to the overall score. Here it can be seen that the domain scores for 'Wellbeing' have returned to the same levels at follow-up as they were at pre-therapy going from 17.50 to 15 and back to 17.50. 'Functioning' has returned to approximately half way between the pre-therapy level of 16.67 and the post-therapy level of 9.17 with a follow-up score of 12.73. Significantly, however, 'Problems' have maintained their post-therapy level going from 20 at pre-therapy down to 10 at post-therapy and staying at this level at follow-up. Similar to 'Wellbeing', the 'Risk' score has returned to the same levels at follow-up as they were at pre-therapy going from 3.33 to 1.67 and back to 3.33.

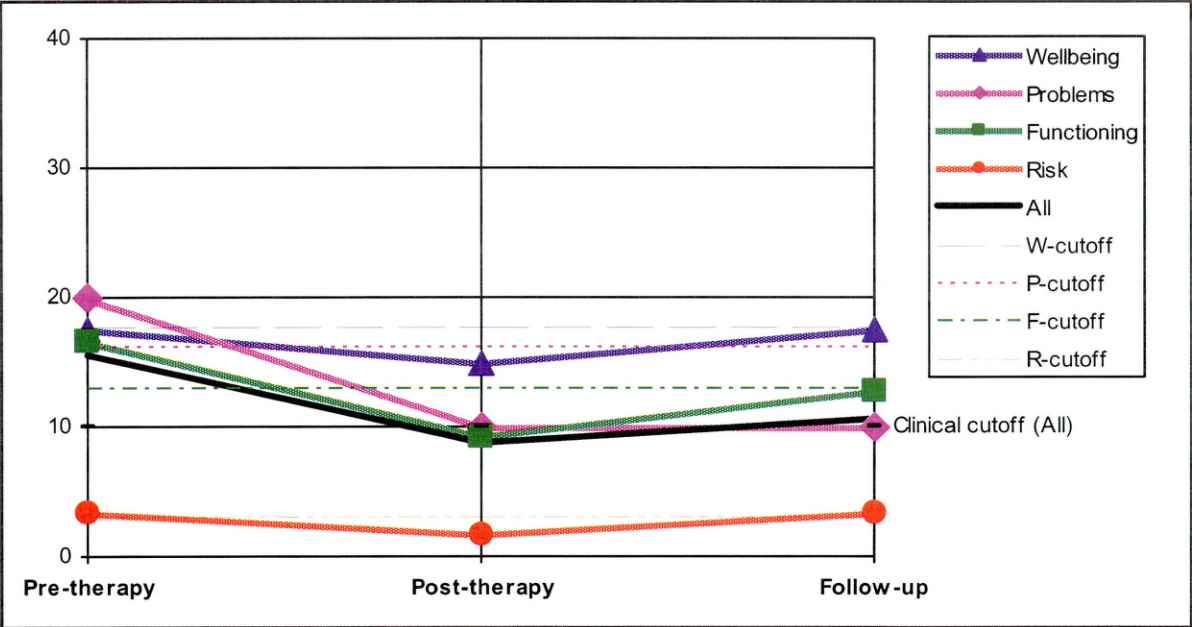


Figure 7-4 Graph of Andrea’s CORE-OM scores

With regard to changes in severity levels (see Section for details 6.6.2.1), Table 7-6 below demonstrates a shift from the low end of the ‘moderate level’ (severity level 3) of distress at pre-therapy, to the high end of ‘low level’ (severity level 1) distress at post-therapy, and a return to a ‘mild level’ (severity level 2) of clinical distress at follow-up. Interestingly, these changes seem to closely resemble the pattern of change indicated by the average ratings of the extensiveness and significance of Andrea’s problem narratives (see Table 7-1) which moved from the ‘moderate’ (level 3) range at pre-therapy to ‘minimal’ (level 1) range at post-therapy and then to ‘mild/brief’ (level 2) at follow-up.

CORE-OM pre-therapy severity	CORE-OM post-therapy severity	CORE-OM follow up severity
Moderate (3)	Low level (1)	Mild (2)

Table 7-6 Andrea’s CORE-OM severity levels

Looking beneath these aggregate scores reveals some interesting item responses. Table 7-7 below sets out the individual CORE-OM items that have changed by more than one point from pre to post-therapy. The largest shift in item scores was reported for “*I have felt terribly alone and isolated*” which changed from ‘Often’ to ‘Not at all’. Two further significant shifts where reported: “*I have been able to do most things I needed to*” went from ‘Only occasionally’ to ‘Often’, and “*I have felt unhappy*” went from ‘Often’ to ‘Only occasionally’. Interestingly, one item showed significant deterioration from pre to post-therapy: “*I have felt optimistic about my future*” went from ‘Often’ to ‘Only occasionally’. This appears to be a potential anomaly as it does not fit with any other indicators of change.

CORE-OM Item	Pre Score	Post Score	Diff
I have felt terribly alone and isolated	3	0	3
I have been able to do most things I needed to	3	1	2
I have felt unhappy	3	1	2
I have felt optimistic about my future	1	3	-2

Table 7-7 Andrea’s CORE-OM pre-post item changes

Similarly, the individual CORE-OM items which changed by more than 1 point from post-therapy to six month follow-up are presented in Table 7-8 below. The item “*I have felt terribly alone and isolated*” has gone from ‘Not at all’ to ‘Sometimes’ and the item “*I have been irritable when with other people*” has gone from ‘Only occasionally’ to ‘Often’.

CORE-OM Item	Post Score	Follow up	Diff
I have felt terribly alone and isolated	0	2	-2
I have been irritable when with other people	1	3	-2

Table 7-8 Andrea’s CORE-OM post-follow up item changes

7.1.9 Andrea’s reflections on the LSM and CORE-OM methods

At the end of the post-therapy and follow-up interview, Andrea was asked to reflect on her experience of using the CORE-OM questionnaire and the Life Space Map, and the value of the different methods in determining change. The following gives an impression of how Andrea experienced the different methods.

On being shown her pre-therapy LSM at the post-therapy interview, Andrea could clearly see a dramatic difference: “*Oh that’s dreadful isn’t it? That just shows you my brains been scrambled. That’s quite scrambled. That is scrambled brain... That’s just sitting night after night and just thinking negative...*” and “*Oh God so look at that... That was turmoil. That was my mental state...*”. On being asked if her pre-therapy LSM captured her state as it was, Andrea replied “*Aye. Even not even reading it and just looking at that... It’s just confusion. There’s no pattern there that says I’m okay. It’s so different with the lines and the design and the colours. It’s just muddle. Absolute muddle. Dreadful.*” These responses clearly show the power of the LSM to facilitate a person’s reflection on change from before to after therapy. Andrea expanded on this saying the LSM helped to take stock of “*where I’ve come from, where I am now and realizing the severity of how I was feeling a way back then. How ill I felt and the difference... That’s good you kept that because I remember doing it but when I look at it now... but that was me... [Does that seem worse than you remember you were?] Aye, oh aye... brings it home*” and “*Because somebody would come in here if you didn’t have that... would they really remember it the way it was? I don’t think so.*” Here

Andrea poignantly related that the image of the LSM was like taking a photocopy of the brain: *“That’s a photocopy of the brain at the time as far as I’m concerned. That’s how you’re feeling at the time. That’s a good reference.”*

In comparison, on being asked to look at the pre and post CORE-OM questionnaires, Andrea could discern a difference but it was nowhere near as significant: *“I think there’s obviously a more positive person there coming up, isn’t there? Not so negative... More normal”* and *“I don’t know if the change is huge but there is a change”*. This was corroborated by Andrea when asked which representation she felt was more accurate: *“I think this {LSM}. I think because you’re actually applying your thoughts onto paper. I mean that’s {CORE} like ticking wee boxes... It’s actually quite hard to decipher isn’t it? You’ve got 1,2,3,4,5 boxes there.”* Andrea went on to describe a number of issues she had with the CORE-OM questionnaire. Firstly, Andrea felt there were too many boxes: *“It’s hard actually sometimes to tick really, to focus on the tick. [Like to put yourself into a box?] Yes. Into a box. Honestly... I think they’re too many boxes”*. Andrea also felt the overall questionnaire could be shortened: *“That could be shortened. Personally because you’re leaving it kind of so spread out that you’re ‘oh I’m not very sure now what would I tick here’. I think there could be less boxes. It would make it easier. It’d be easier because I think oh my god here we go, oh my god, oh right. And if you’re not feeling well the last thing you want is 5 boxes and all these questions.”* Further, Andrea reported difficulty with using the CORE-OM Likert scale: *“With that {CORE} you’ve not got choice, you’ve got to study and go that’s 1,2,3,4”*. Andrea expanded on this sense of being confined to a limited set of choices and the difficulty she found with accurately rating herself using the provided scale: *“What one is it, I’m not sure. But maybe ‘Sometimes’, ‘Often’... ‘Sometime’ and ‘Often’ to me is the same question. ‘Not at all’, ‘Only occasionally’. Is ‘Only occasionally’ not ‘Sometimes’? Is that not the same question? ... ‘Only occasionally’, ‘Sometimes’ or ‘Often’. To me that could be minimized”*. Clearly Andrea felt the responses she gave using the CORE-OM could not be uncomplicatedly used as a quantification of her problems, functioning and wellbeing.

Significantly, Andrea felt that people who are mentally suffering may well struggle with the cognitive task of completing the questionnaire: *“And if you’ve got depression. Oh for goodness sake, oh god I’ve got to do this now so, you don’t know how accurate that person’s answering is when they’re in a state of depression. They may be struggling and going ‘oh I don’t know, maybe that one or maybe that one’... Because I mean even the size of the box is off putting. They’re so toty. There’re so... and it looks hundreds. They look like hundreds and hundreds of boxes. You’re like, ‘oh my god have I got to tick all these boxes?’ ... when you’re feeling depressed it’s quite overwhelming. Oh my god have I got to tick all them?”* Andrea compared this task to being asked to sit an exam or doing homework: *“It’s like sitting an exam. In you come dear, would you like to... What... what... I’ve got depression, I’ve to fill that in? It’s a big joke when you’re not well...”* and *“that’s like homework... that’s like work. Maybe it’s me being lazy but it’s like work for somebody*

who's thinking is the problem.” Here Andrea uses a beautiful analogy to describe the difficulty of asking someone to cognitively express themselves when it is their cognitive processes which are not working well: “It’s like asking me to do a marathon with a broken leg. You know what I mean. Because that’s what you’re dealing with. You’re dealing with the mind. Are you with me? And it’s the mind that’s ill. So that’s an ordeal, or it can be for somebody that’s got anxiety.”

By comparison Andrea felt completing the LSM was a less mentally challenging process: *“That’s {LSM} easier because that’s self expression. You’re restricted, you’re really restricted here {CORE} right. That’s {LSM} self expression so, that’s letting your hand do the walking and the drawing.” and “That’s {LSM} flowing. I mean that’s your anger... And you’re writing down things and... that’s more natural. That’s {CORE} coming from the mind - you’re concentrating doing that, with this {LSM} you’re concentrating but it’s easier. You’re going with it. You’re going with the flow of how you’re feeling. With this {CORE} you’re going, wait a minute, oh. I don’t know.”* Here Andrea clearly reports that the two different approaches worked in very different ways, and that they seemed to access different parts of the brain: *“Well, that’s coming from different angles. Different parts of the brain”*

7.1.10 Case study summary

This case study reveals a number of key results in terms of the aims of the current research:

- The Life Space Mapping method can evoke a rich, in depth narrative about the kinds of problems, the causes of these problems, and resources a client can adopt to cope with problems in their life, and to relate these from their own frame of reference. Further, the LSM interview can allow people to reflect on the changes and the attributions for these changes over the duration of therapy.
- The case study demonstrates that it is possible to analyse the client’s reflective narrative to identify changes in the extensiveness and significance of these problems, causes, resources, changes and attributions, and that there is potential to compare aspects of this to changes indicated by the CORE-OM.
- The LSM approach was able to reveal more subtle changes over the duration of therapy compared to measuring fluctuations in intensity as with the CORE-OM. For example, shifts in time perspectives of problems (see Table 7-1 Summary of Andrea's problem narratives), a greater differentiation of the causes of problems (see Table 7-2 Summary of Andrea's causation narratives), and changes in the use of coping resources over time (see Table 7-3 Summary of Andrea's resource / coping narratives) emerged.

- The LSM interview facilitated the client's own conceptualisation of change rather than this being predefined as with the CORE-OM (see Table 7-4 Summary of Andrea's change narratives).
- Of particular interest, the LSM approach was able to reveal a multitude of reasons for the changes experienced in therapy. Rather than therapy being a sole causal effect, change was contextualised within the person's wider social world including the influence of external life pressures, new medication, spiritual support and guidance, exercise and getting out more and the passage of time itself (see Table 7-5 Summary of Andrea's attribution narratives).
- The case study demonstrates that a creative, visual approach to investigating the outcomes of therapy can be highly welcomed by clients. Such an approach can allow a person to directly apply their thoughts onto paper and express themselves freely. In comparison, the CORE-OM can be experienced as being restrictive and potentially overwhelming, especially for someone who is struggling cognitively.

7.2 Part 2: Quantitative CORE-OM outcome data

In comparison to the above in-depth case study which presents a largely qualitative view of outcome, the following section presents the results of the overall study in a more traditional quantitative form. Here the emphasis can be seen to focus on a progressive summarisation of the numbers. The mean CORE-OM scores are presented for all participants in Appendix H for pre-therapy, post-therapy and at follow-up. These tables show the clinical score calculated by multiplying the mean CORE-OM score by 10. As well as the overall mean, values are shown for each of the domain scores of Wellbeing, Problems, Functioning and Risk, along with the “All minus risk” value. To better understand the meaning and significance of these values, the data was then summarised and analysed in terms of changes in the severity level from pre to follow-up and to follow-up. This can be seen to give an overall view of the pattern of outcomes for all participants in the study. Additionally, the reliable and clinically significant improvement was calculated. Finally, the overall effect size of the differences is presented. This data is then compared to the results of a large scale practice based outcome study.

7.2.1 CORE-OM severity levels

Table 7-9 provides a graphical indicator of the changes in severity for the 17 participants who completed both pre and post-therapy CORE-OM questionnaires. Severity levels have been shaded to enhance the visual interpretation of patterns of change (see Section 6.6.2 for further details) such that the range of scores from ‘Healthy’ (0) to ‘Severe’ (5) go from light to dark.

Client ID	CORE-OM pre-therapy severity	CORE-OM post-therapy severity	CORE-OM follow up severity
001	2	0	0
002	4	2	2
003	4	4	
006	3	1	
008	3	1	2
014	5	4	3
017	2	1	2
019	4	2	1
020	2	0	
021	2	0	0
032	4	1	1
033	5	1	
037	1	0	0
038	4	3	
040	3	0	
041	3	1	
043	4	5	

Table 7-9 CORE severity levels per participant

This method of analysis immediately highlights some interesting cases. Participant 008 appears to have improved at the end of therapy, but gotten worse at follow-up. Participant 019 appears to have improved significantly at the end of therapy, but is still in the ‘clinical’ range, then moves out of this at follow-up. Participant 033 seems to have undergone significant change from ‘severe’ to ‘mild’. Conversely, participant 043 seems to have gotten worse by the end of therapy going from the ‘moderate to severe’ range, to the ‘severe’ range.

With regard to the overall distribution of participants, Table 7-10 clearly shows a shift from more severe levels to less severe levels over the course of the study. Prior to therapy, over 90% of participants were in the clinical range, with over 16% in the severe level. After therapy, this had dropped to around 35% of participants in the clinical range, and only one in the severe level. At follow-up, no participants were in the severe or moderate to severe levels, with only one participant at the moderate level.

Clinical score		Severity level	Pre therapy (n)	Post therapy (n)	Follow up (n)
0 - 5.9	Non clinical	Healthy (0)	0	5	3
6 - 9.9		Low level (1)	4	6	2
10 - 14.9	Clinical	Mild level (2)	9	2	3
15 - 19.9		Moderate level (3)	11	1	1
20 - 24.9		Moderate to severe level (4)	12	2	0
25 - 40		Severe level (5)	7	1	0
Total			43	17	9

Table 7-10 CORE-OM severity level summary

Though on the face of it these results seem to indicate a very positive overall outcome for participants in the study, a more detailed analysis is required to reveal the full story. The large drop out rate from pre to post-therapy (60%) may well hide significant information. For example, is it the case that those participants who were in the more severe levels of distress simply did not return for a post-therapy interview leaving a biased sample of participants at the end of therapy and at follow-up? Even for those who did complete an end of therapy interview, this aggregate level of analysis can not tell us if all participants improved on their CORE-OM scores by the end of therapy or if some actually got worse. To answer this level of question, a more detailed analysis is required.

Clinical score		Severity level	Dropped out (n)	Attended Post therapy (n)	Attended Follow up (n)
0 - 5.9	Non clinical	Healthy (0)	0	0	0
6 - 9.9		Low level (1)	3 (12%)	1 (6%)	1 (11%)
10 - 14.9	Clinical	Mild level (2)	5 (19%)	4 (24%)	3 (33%)
15 - 19.9		Moderate level (3)	7 (27%)	4 (24%)	1 (11%)
20 - 24.9		Moderate to severe level (4)	6 (23%)	6 (35%)	3 (33%)
25 - 40		Severe level (5)	5 (19%)	2 (12%)	1 (11%)
Total			26	17	9

Table 7-11 CORE-OM pre-therapy severity level by retention

Table 7-11 shows the CORE-OM pre-therapy severity level dependent on the stage of retention for participants. This data indicates that a significantly higher proportion of participants with severe distress dropped out of the study (19%) compared to those who attended post-therapy interviews (12%), and those who continued on to the follow-up stage (11%). Interestingly, a significantly higher proportion of participants with low levels of distress also dropped out of the study (12%) compared to those who attended a post-therapy interview (6%). This analysis of severity levels gives a good initial impression of the data. However, it can not tell us whether the shifts were statistically reliable. For this, a more detailed analysis is required.

7.2.2 *Reliable and clinically significant improvement*

Table 7-12 shows the participants whose CORE-OM scores indicate reliable and clinically significant improvement as per the criteria suggested by Connell et al, (2007) (see Section 6.6.2.2 for further details). Three (18%) of the participants (003, 017 and 038) did not meet the criteria for statistically reliable change (i.e. did not change by more than the RCI of 5). Six (35%) of the participants (003, 014, 019, 037, 038, 043) did not meet the criteria for clinically significant change (i.e. did not drop below the clinical cut-off point of 10)

Client ID	pre therapy score	post therapy score	Difference pre-post	Reliable change	Clinical change	Reliable + Clinical change
001	10.00	3.94	6.06	✓	✓	✓
002	23.82	10.00	13.82	✓	✓	✓
003	23.24	21.76	1.47			
006	16.47	7.94	8.53	✓	✓	✓
008	15.59	8.82	6.76	✓	✓	✓
014	29.41	22.06	7.35	✓		
017	11.18	7.94	3.24		✓	
019	22.94	13.82	9.12	✓		
020	12.12	0.88	11.24	✓	✓	✓
021	11.18	2.06	9.12	✓	✓	✓
032	20.88	9.12	11.76	✓	✓	✓
033	27.35	9.12	18.24	✓	✓	✓
037	8.82	2.94	5.88	✓		
038	22.65	19.71	2.94			
040	15.45	4.85	10.61	✓	✓	✓
041	16.36	8.82	7.54	✓	✓	✓
043	24.41	29.41	-5.00	✓		
Count				14	11	10
Percent				82%	65%	59%

Table 7-12 Reliable and clinically significant improvement at end of therapy

Combining these criteria, 7 (41%) of the 17 participants failed to demonstrate reliable and clinically significant improvement in their CORE-OM score. Of these, two (12%) demonstrated reliable change, but not sufficiently to move their follow-up score out of the clinical range. A further one (6%) showed reliable change, but did not begin within the clinical range, and one (6%)

showed reliable deterioration from before until after counselling. This left 10 (59%) of the participants who demonstrated reliable and clinically significant improvement on their CORE-OM score from before until after counselling. Of these, the difference between pre and post scores ranged from 6.06 to 18.24, with a mean of 10.37 (S.D. 3.48).

Table 7-13 shows the same analysis for the nine participants who completed a follow-up questionnaire. It can be seen that fewer participants demonstrated both reliable and clinically significant change on their CORE-OM scores from pre-therapy to follow-up than from pre-therapy to post-therapy. Eight (89%) of the nine follow-up participants showed reliable change at the end of therapy but only seven (78%) demonstrated this at the follow-up stage. More significantly, compared to the six (67%) participants who demonstrated clinically significant improvement in their CORE-OM scores at the end of therapy, only four (44%) participants showed this at follow-up. Combining these criteria meant that four (44%) of the nine participants demonstrated reliable and clinically significant improvement at the follow-up stage compare to five (56%) at post-therapy.

Client ID	CORE pre score	CORE post score	CORE follow up score	Difference		Reliable change		Clinical change		Reliable + Clinical change	
				P	F	P	F	P	F	P	F
001	10.00	3.94	1.47	6.06	8.53	✓	✓	✓	✓	✓	✓
002	23.82	10.00	13.75	13.82	10.07	✓	✓	✓		✓	
008	15.59	8.82	10.61	6.76	4.98	✓		✓		✓	
014	29.41	22.06	18.24	7.35	11.18	✓	✓				
017	11.18	7.94	10.88	3.24	0.29			✓			
019	22.94	13.82	9.41	9.12	13.53	✓	✓		✓		✓
021	11.18	2.06	2.35	9.12	8.82	✓	✓	✓	✓	✓	✓
032	20.88	9.12	6.76	11.76	14.12	✓	✓	✓	✓	✓	✓
037	8.82	2.94	2.94	5.88	5.88	✓	✓				
Count						8	7	6	4	5	4
Percent						89%	78%	67%	44%	56%	44%

Table 7-13 Reliable and clinically significant improvement at follow-up

It is interesting to note the pattern of these differences between the end of therapy and follow-up. Three of the participants (002, 008 and 017) moved from a non-clinical score at the end of therapy to a clinical score at follow-up indicating a possible ‘relapse’ after therapy. However, one participant (019) moved from a clinical score at the end of therapy to a non clinical score at follow-up, suggesting that the reliable changes made during therapy had allowed a clinically significant improvement after therapy was over. Similarly, two participants (001 and 032) showed that the reliable and clinically significant improvement at the end of therapy had continued after therapy producing even smaller CORE-OM scores at follow-up.

7.2.3 Pre-post therapy score effect size

The effect size for this sample was calculated for all participants who completed a post-therapy interview as well as only those who demonstrated reliable and clinically significant improvement (RCSI). Table 7-14 below presents the results of this calculation as detailed in method (see Section 6.6.2.3).

Sample	n	Pre Therapy		Post Therapy		Pre-Post difference		Effect Size
		Mean	S.D.	Mean	S.D.	Mean	S.D.	
All	17	18.35	6.26	10.78	7.79	7.57	5.09	1.21
RCSI	10	16.92	5.30	6.55	3.15	10.37	3.47	1.96

Table 7-14 Pre-post therapy score effect size

The overall effect size for all participants who completed a post-therapy interview was 1.21. For the 10 participants who demonstrated reliable and clinically significant improvement, the effect size was 1.96. These are both considered large effect sizes (greater than 0.8) as defined by Cohen (1992).

7.2.4 Comparison with other practice-based studies

The above results can be compared to other published practice based studies to gain a comparison of the relative effectiveness of the therapy. For example, a recent article by Stiles et al (2006) published the results of data collected from 1309 NHS patients over a 3 year period. The article reports that patients showed substantial gains, improving on average from 17.41 (S.D.=6.52) to 8.50 (S.D.=6.27) on the CORE-OM, a difference of 8.9 (S.D.=6.81). Additionally, the overall treatment effect size was given as 1.36. Further, the article reports the average improvement rate using the benchmark of reliable and clinically significant improvement (see Section 6.3.1.5) across all therapies was 61%.

In the present study, participants showed similar gains on the CORE-OM over the duration of therapy, improving on average from a score of 18.35 (S.D.=6.26) to a score of 10.78 (S.D.=7.79), a difference of 7.57 (S.D.=5.09) giving an overall treatment effect size of 1.21 (see Table 7-14 above). Similarly, the average improvement rate using the reliable and clinically significant improvement benchmarks was 59% (see Table 7-12 above). This comparison indicates that the results from the present study are generally comparable to a large scale outcome study based within the UK National Health Service.

7.2.5 *Quantitative analysis summary*

This quantitative analysis reveals a number of key results in terms of the aims of the study:

- The CORE-OM data is able to provide a succinct overview of the patterns of change for all participants over the duration of the study (see Table 7-9 CORE severity levels per participant) which is not possible with the Life Space Mapping method.
- Analysis of the CORE-OM severity levels allows interesting cases to be easily and routinely identified and flagged for closer examination without requiring a detailed analysis of all cases (see Table 7-9 CORE severity levels per participant).
- Potential biases in recruitment and other systematic problems can be revealed in terms of analysing differences in participant characteristics for early drop outs versus completers (see Table 7-11 CORE-OM pre-therapy severity level by retention).
- The availability of normalised data for the CORE-OM can confirm that participants achieved an objectively recognisable (clinically significant) and statistically reliable level of change, rather than a purely subjective level of change (see Table 7-12 Reliable and clinically significant improvement at end of therapy).
- Results from the present study can be seen as comparable to a large scale practice based outcome study (see Section 7.2.4).

7.3 Part 3: Montage of Life Space Maps and CORE-OM graphs

Following is a presentation of a selection of ‘caselets’ demonstrating a variety of styles of Life Space Maps which participants have used. The data is presented as a montage of Life Space Maps, CORE-OM graphs and brief textual summaries in order to give a diverse yet interconnected view of different participants. The intent is to provide a broader view of the research data, rather than a detailed analysis, such that differences and similarities can be seen, both between the methods and between participants. To aid an overall view of the data, the textual descriptions of each case have been kept deliberately brief.

Note that in the following Life Space Maps, all names have been edited out of the diagrams and text. As the intent is to give an overview, the diagrams have been kept deliberately small scale. Were this has made it difficult to read the words contained in the LSMs, these have been included in the accompanying commentary. Each LSM is identified by a number indicating the participant and the stage of interview, such that 002-1 denotes participant 002 at the pre-therapy stage, while 002-2 denotes the post-therapy interview, and 002-3 the follow-up stage. Where more than one map was constructed in an interview, a sequential letter has been added to the above numbering scheme.

Note also that the CORE-OM graphs use different domain cut-offs for male versus female participants for the domains of Wellbeing, Problems, Functioning and Risk as per the original CORE-OM scoring scheme, whereas the new single clinical cut off score of 10.00 has been used for the overall score.

7.3.1 Participant 002

Participant 002 was a 55 year old female who attended just one session of therapy which she did not find very supportive. Significantly, however, she had previously attended couples counselling at the centre for 9 sessions which she had found very beneficial. This had finished approximately four months prior to attending her individual therapy which was part of the researcher project. This participant demonstrated clinically significant and statistically reliable change on the CORE-OM from pre-therapy (mean score 23.82) to post-therapy (mean score 10.00), with a clinically significant but not statistically reliable deterioration at follow-up (mean score 13.75). Her Life Space Maps consisted primarily of words and statements, sometimes linked together with lines. She found the life space mapping task to be significantly more beneficial to her than the

counselling session, and helped her to make sense of and gain something from the unhelpful experience of seeing the counsellor.

7.3.1.1 Participant 002 pre-therapy interview (002-1)

The pre-therapy interview entailed quite a painful process of recollection. The participant got quite upset on a few occasions, with the researcher gently reminding her that therapy would offer a chance to talk through things in more depth. The main theme to emerge from the interview was difficulty with relationships with men, stemming from years of previous verbal and physical abuse from her ex-husband. Though he was no longer in her life, the scars from this were still very evident, and she had never really had a chance to talk in depth about the ‘really bad’ things that he had done to her.

The words on the Life Space Map poignantly illustrate this and other themes: *“Years of abuse, withdrawn into myself 19-20 years”, “Depression really bad”, “20 years left”, “Angry because did not stand up for self”, “Stuck in a rut. Black hole. Don’t know how to be me”, “Fear my worst nightmare”, “Relationship scares”* and *“Feel angry because I never done anything about my life and I could like a zombie so submissive I don’t know who I am and what I want”*. Additionally, there was also mention of positive relationships with her *“Son and Daughter”*, but that she could *“Love easier daughter”* compared to her son, whom she was sometimes afraid of. She felt she could *“talk better”* to her teenage *“Grandson”* whom she had a good relationship with. There was a sense here of knowing that her fear of her son was not okay, of trying to make up for this with her grandson but still realising that she was sometimes scared of him, of knowing that this stemmed from her problems of relating to men.

7.3.1.2 Participant 002 post-therapy interview (002-2)

At the post-therapy interview, the participant reported being in a very different place. Though the fear was still there, it no longer ruled her life and she could stand back and ‘see’ it. The main focus for her was to *“rid”* herself of her *“fear”*. Her self *“confidence”* had returned, but she was *“very aware”* that she needed to *“check”* herself in terms of fear and not let it get in the way. Additionally, strong positive themes of *‘Freedom’*, *‘Liberation’*, and *‘Feel good’* were also present, replacing previous themes around self anger.

Overall, the participant reported feeling very positive about things and confident about her ability to continue to cope well. There was a sense of this stage representing a ‘marker’, of really knowing that no one had the power to abuse her ever again. In this sense, her ending of therapy after a single session had been quite an empowering process as she had felt dismissed and belittled by her male therapist. Even though this was obviously a painful experience, she expressed that a light had gone on for her, that in conjunction with doing the pre-therapy LSM, this had allowed her to face her fear and anger, and to no longer feel stuck in the past.

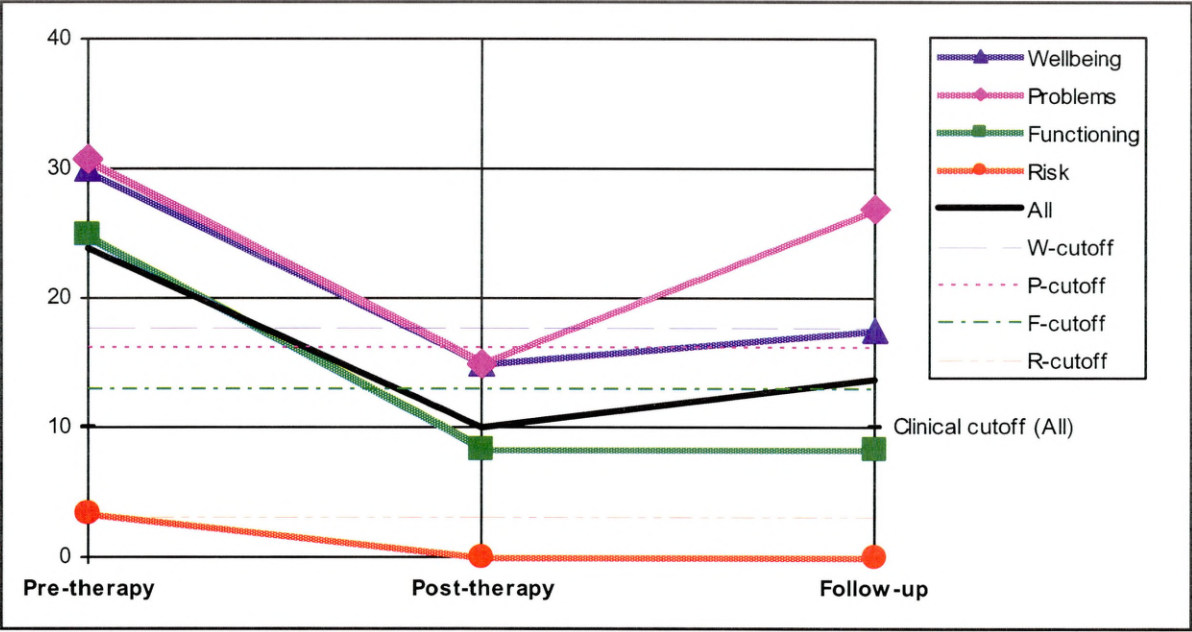


Figure 7-5 Participant 002 CORE-OM graph

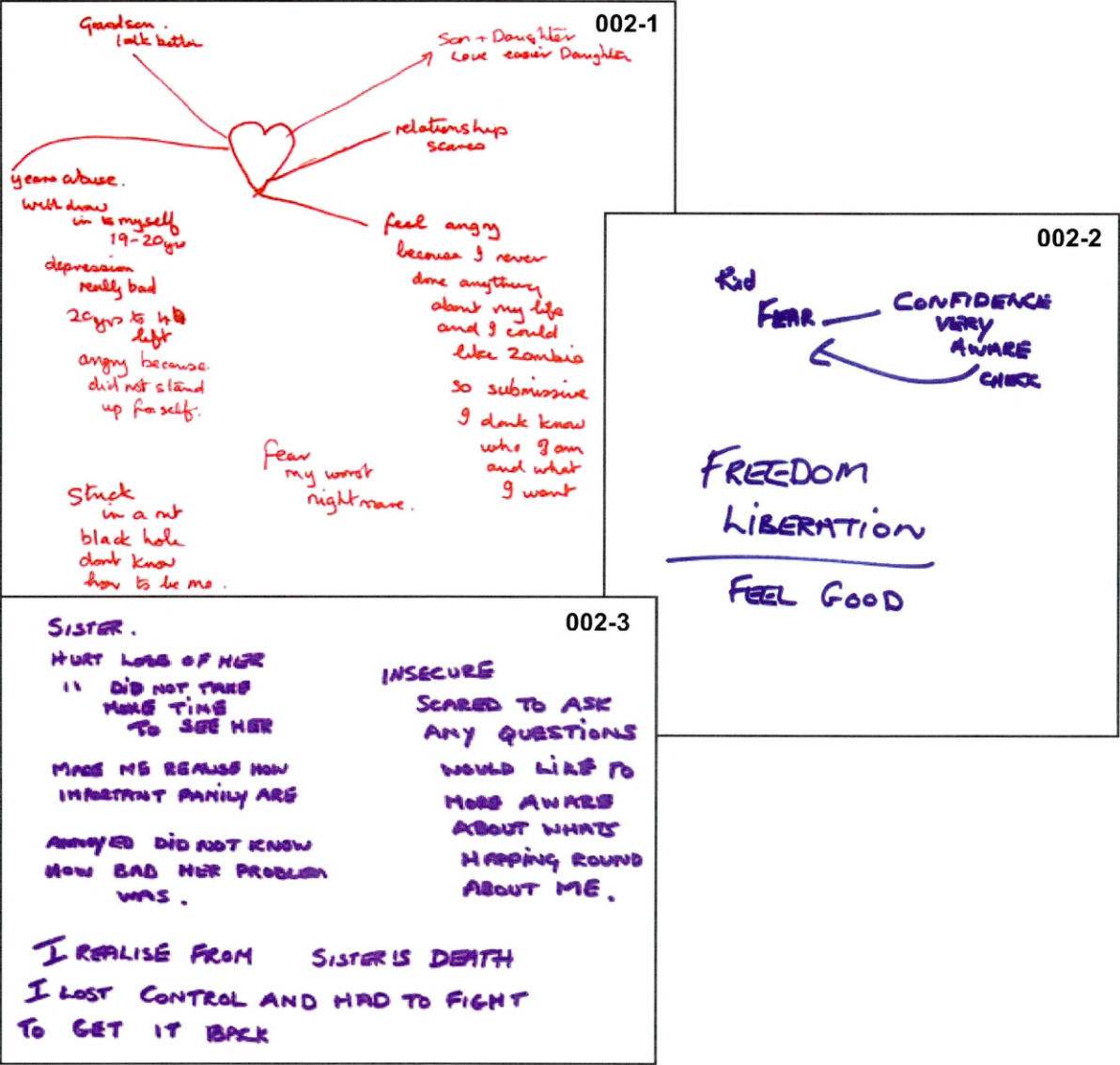


Figure 7-6 Participant 002 Life Space Maps

7.3.1.3 Participant 002 follow-up interview (002-3)

The follow-up interview revealed a greater sense of turmoil in this participant’s life compared to the post-therapy interview. In particular, the recent death of her sister had thrown up a lot of things, as indicated in the words used below to illustrate the LSM: *“Sister. Hurt, loss of her. Did not take time to see her”, “Made me realise how important family are”, “Annoyed did not know how bad her problem was”, “I realise from sister’s death I lost control and had to fight to get it back”, “Insecure – Scared to ask any questions”, and “Would like to be more aware about what’s happening around about me”*. Though a painful experience, this revealed to her another example of a situation of not asking questions, of seeing that there was still work to do in terms of expressing her true feelings. There was no longer any concern of being abused in relationships, but something stopped her being true to herself, of not saying exactly what she felt. She could see this stemmed from childhood, of things being kept in the family and told not to ask questions. Here there was a sense of things going to a deeper level, of realising that habitual ways of reacting did not fit for her anymore.

7.3.2 Participant 017

Participant 017 was a 31 year old male who attended 17 sessions of counselling initially for anger management. This participant demonstrated clinically significant but not statistically reliable change on the CORE-OM from pre-therapy (mean score 11.18) to post-therapy (mean score 7.94), with clinically significant but not statistically reliable deterioration at follow-up (mean score 10.88). His maps consisted mainly of written statements over multiple pages.

7.3.2.1 Participant 017 pre-therapy interview (017-1)

This participant used a number of sheets in the pre-therapy interview to express himself around a central ‘flow diagram’ of *“Life style change”*: *“Social life”, “work”, “at home”, “family and friends”, “quality relaxing time”, “exercise”, and “work & travel”*. The following transcripts from each of the sheets capture the main themes from the interview:

a)	<i>Family life. My family mean everything to me so in a way I feel I have not been a good brother to my older brother. So to change to be more supportive and caring to him and socially active with him would be good. I also feel that mum and dad are getting old and could die anytime. So I am scared and fearful of that.</i>
b)	<i>Thoughts of travel. The past has made me think about travel. So in a way I have the thoughts of past travel experiences that I may want to make a change now or future to go away again. Lifestyle change is important to me just now because I feel that if I don't I will not get the opportunity again so want to get some excitement or happiness in this way</i>
c)	<i>Why I'm here. The purpose of myself coming to counselling is to develop better understanding and communicating to people. At times I cannot express myself in a way in company with others, so feel a bit nervous around people. I want to develop my thoughts better and understand them.</i> <i>Life. In a life perspective, at present I feel no ambition to fulfil any potential of skills or creative ability. But travelling or moving abroad appeals to a better advantage to what I have at present. Don't understand my dreams to achieve my own goals. So I am a bit confused to whereabouts my life direction is going.</i>
d)	<i>Girlfriend. Have just come to an understanding with each other that we get on and can make a relationship. But sometimes trust plays a part. But we do love each other. But I want maybe more time to know if it really is her that I want.</i>

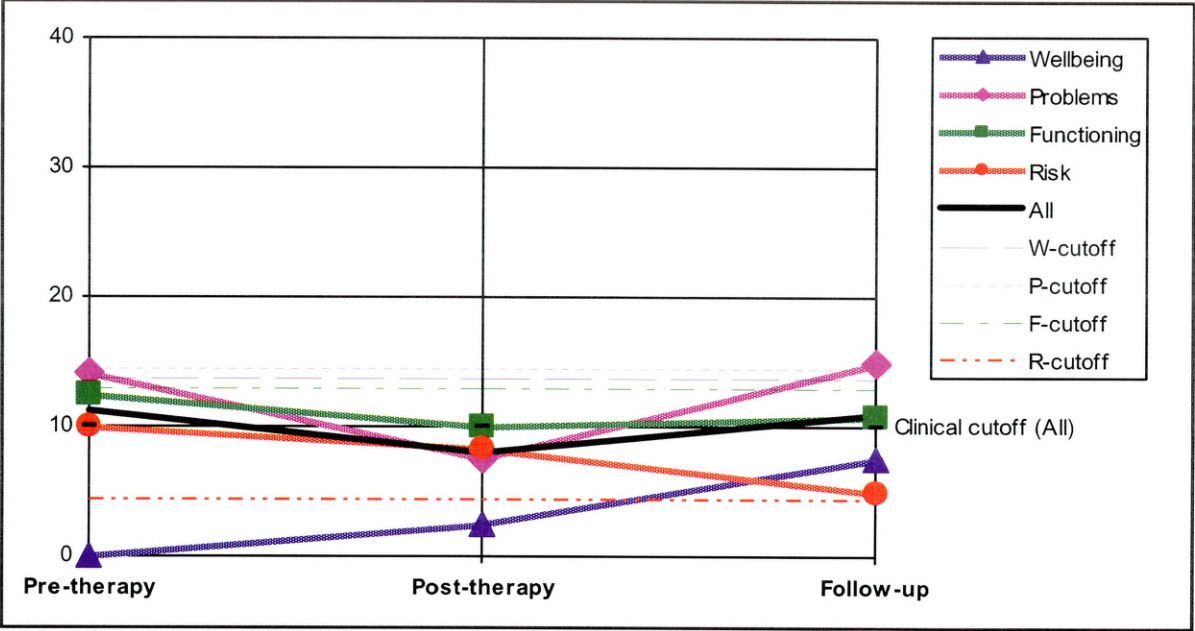


Figure 7-7 Participant 017 CORE-OM graph

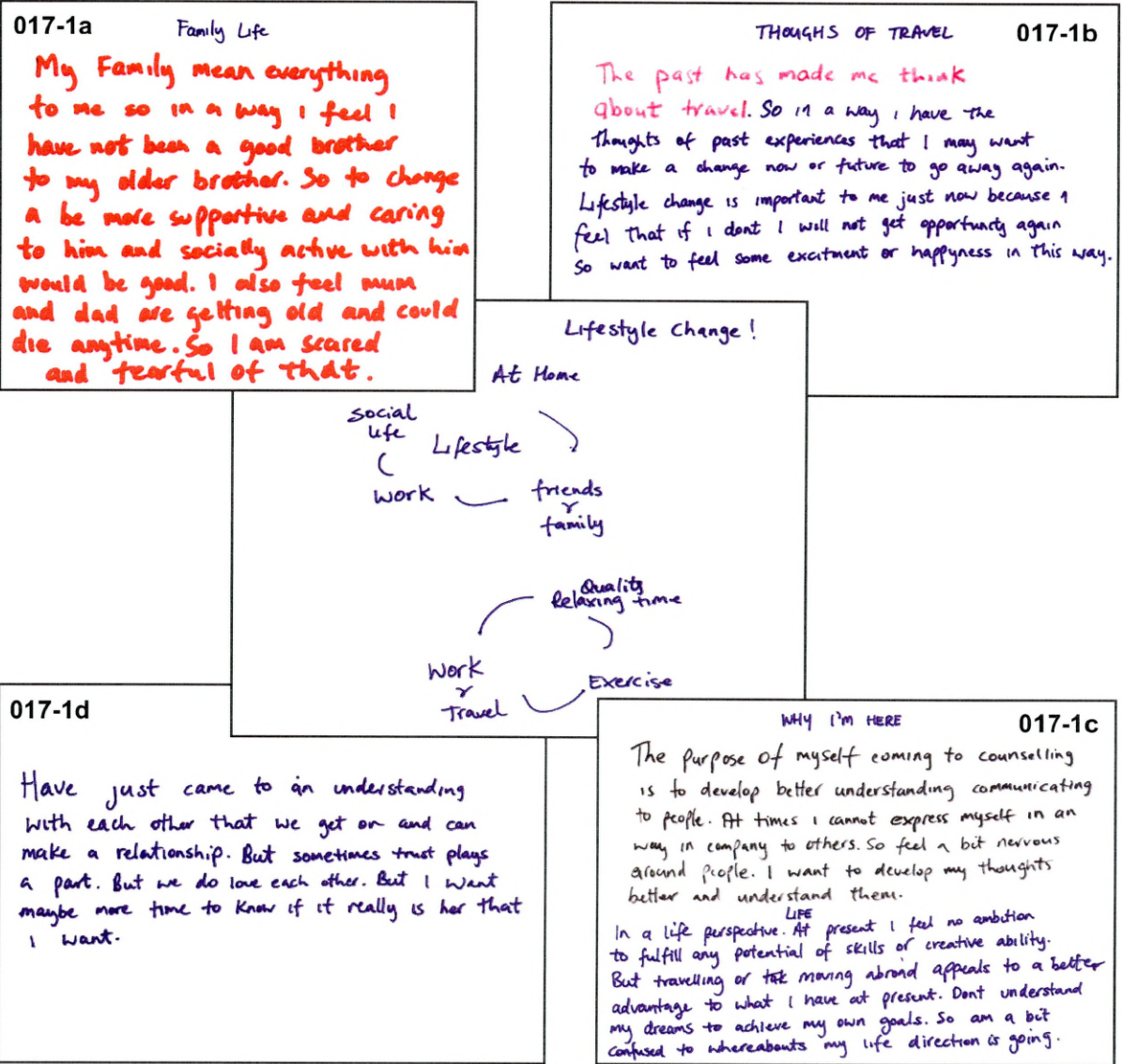


Figure 7-8 Participant 017 pre-therapy Life Space Maps

7.3.2.2 Participant 017 post-therapy interview (017-2)

During the post-therapy interview, this participant again constructed a 'flow diagram' style of Life Space Map with the words: "*Work*", "*Sport activities*", "*Visit family*", "*Visit friends*", "*Socialise in pub*". Another sheet was used to express his "*Emotional outlook*" and his "*needs*" consisting of the following statements: "*Try to be assertive more, by awareness when my moods are low*", "*I will communicate with friends and family*", "*Trying to reach out to change in my career prospects*", "*Want to open up my horizons by broadening them*", and "*Looking at information to do this*". This participant felt he had benefited somewhat from counselling, that he had become more aware of how he was feeling and was now more relaxed around other people. However, he had also separated from his girlfriend and was still feeling uncertain about the future.

7.3.2.3 Participant 017 follow-up interview (017-3)

The follow-up interview consisted of constructing a largely 'letter to self' style Life Space Map:

Structure of life at present. My family and friends are my real base at moment. As a solid structure for me, they seem to support my emotional state of mind and build my confidence at whatever tasks that lie ahead of me in future life. Especially my mother and father without them and their help I may have suppressed feelings and [been] depressed. But I am feeling ok and comfortable at present. My reason for coming to counselling was to express my feelings and understand them!

I feel I did this. But to my cost I lost my girlfriend as after one of the sessions I had a chat and expressed myself with words of anger that I talked about in session and told her deep rooted emotions that I regretted instantly when she left the room. As a result we fell out and I have not got over it emotionally. I pretend life is good without her but I'm not happy as I was when with ex girlfriend. I go out socially and life is ok with communicating with people and am more at ease with myself when out, but anxiety is still there but not as extreme.

I have met girls in social places but find emotion uncomfortable by comparing them to ex. But am going to sporting centres to keep active and get my enjoyment out of that. Would like to get married and meet the right person before my parents are getting old and I don't want to be too old to raise children, and would like my parents to have grandchild. I am not religious well seriously and would go back to church but would feel hypocritical so don't bother. At stage of my life don't like drink and drugs culture and prefer to go outdoors and be free to walk up hills and mounros to get freedom and peace of mind. That is important as in local community the people around it is getting locals annoyed by their behaviour and as a local you seem to get caught up in its misery. So by getting outdoors that is itself a perfect escape to peace of spirit.

My goal just now is to work away as I am doing and save enough money for holiday once a year. Get a career goal by going back to education and bettering myself in some way. Start my own family and try to be secure in myself mentally and emotionally for my own stability.

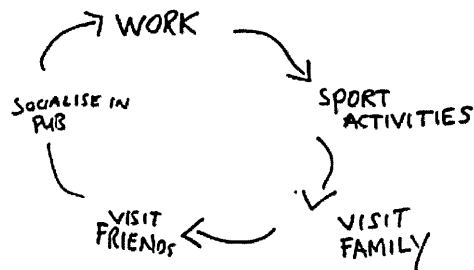
So the past year and a half I have blamed myself for relationship break up with ex. By going round with rollercoaster emotions and hoping she realised I made a mistake but I can't cope and have let go of those feelings so know I am focusing on the future and hope that it happened for reason and learn from it.

I do feel tension when around certain people by this it's just peer pressure friends and don't need them in my life so avoid seeing them now. I also felt pushed as they all have female relationships and I am only one that hasn't got serious girlfriend but learned to deal with that now as well.

My needs are confidence and self belief once I reach these goals then feel I have achieved something and can focus more clearly what my main goals in life are! And also achieve them.

The participant reported that he felt he had relapsed into emotional frames of mind that he had had in the past. Here there was a sense of unachieved goals, as well as a real sense of regret around the ending of his relationship through 'opening up' to his girlfriend about his anger as he had felt encouraged to do by the counsellor.

017-2a



017-2b

EMOTIONAL OUTLOOK (NEEDS)

TRY TO BE ASSERTIVE MORE BY AWARENESS.
WHEN MY MOODS ARE LOW
I WILL COMMUNICATE WITH FRIENDS AND FAMILY

TRYING TO REACH OUT TO
CHANGE IN MY CAREER PROSPECTS.
WANT TO OPEN UP MY HORIZONS BY
LOOKING AT INFORMATION TO DO THIS. **BROADEN THEM.**

Figure 7-9 Participant 017 post-therapy Life Space Maps

017-3a

STRUCTURE OF LIFE AT PRESENT.

MY FAMILY AND FRIENDS ARE MY REAL BASE AT MOMENT.

As a solid structure for me, they seem to support my emotional state of mind and build my confidence at whatever tasks that lie ahead of me in future life. Especially my mother and father without them and their help I may have been suppressed feelings and depressed but I am feeling at ease and comfortable at present. My reason for coming to counselling was to express my feelings and understand them!

I feel I did this, but to my cost I lost my girlfriend as after one of these sessions I had chat and expressed myself with words of anger that I talked about in session and told her deep rooted emotions that I regretted instantly when she left the room. As a result we fell out and I have not got over it emotionally. I pretend life is good without her but not happy as I was with my ex girlfriend. I go out socially and life is ok when communicating with people and am more at ease with myself when out, but merely still there but not as extreme.

I have met girls in social places but am going to be uncomfortable by comparing them to ex. But am going to be sporty centres to keep active and get my enjoyment out of that. Would like to get married and meet the right person before my parents are getting old and I don't want to be too old to raise children, and would like my parents to have grandchild. I am not religious well seriously

and would go back to church but would feel hypocritical as don't bother. At stage of my life don't like drink or drugs culture and prefer to go outdoors and be free to walk up hills and moors to get freedom and peace of mind that is important as in local community the ~~setting~~ around it is getting locals annoyed by their behaviour and as a local it seems to get caught up in its misery so by getting outdoors that is itself a perfect escape to peace of spirit.

My goal just now is to work away as I am doing and save enough money for holiday once a year. Get a career goal by going back to education and bettering myself in some way. Start my own family and try to be secure in myself mentally and emotionally for my own stability. So the past year and a half I have blamed myself for relationship break up with ex. By going round with the roller coaster emotions and hoping she relaxed, made a mistake but I can't cope and have to let go of those feelings so now I am focusing on the future and hope that it happened for reason and learn from it.

I do feel tension when around certain people by this it's just past pressure friends and don't need them in my life so avoid seeing them now I also felt pushed as they all have female relationships and I am only one that hasn't got serious girlfriend but learned to deal with that now as well.

My needs are confidence and self belief once I reach these goals then feel I have achieved something and can focus more clearly what my main goals in life are! and also achieve them

017-3b

Figure 7-10 Participant 017 follow-up Life Space Maps

7.3.3 Participant 032

Participant 032 was a 43 year old female who attended 3 sessions of counselling, initially for anger management and difficulties communicating at her work. This participant demonstrated clinically significant and statistically reliable change on the CORE-OM from pre-therapy (mean score 20.88) to post-therapy (mean score 9.12), with continued gains at follow-up (mean score 6.76). However, after the third counselling session, the participant felt that they were just talking and talking, that they were just dragging up the past and not getting anything out of it. As such, they soon terminated therapy and instead undertook a counselling skills course which they found very rewarding and useful. This participant's Life Space Maps consisted primarily of pictograms and words illustrating the themes outlined below.

7.3.3.1 Participant 032 pre-therapy interview (032-1)

The pre-therapy interview consisted of themes of happiness at home but "*lonely*", "*like my job*" but it is full of "*stress*", only two people she could call "*friends*", very distant from her "*sister*", "*father*" was a Sergeant in the army and ran the house like a camp, up against a brick wall as far as having a "*partner*", "*no confidence*", broken hearted, scared about the "*future*" and "*loss of Mum*", "*confusion*" about "*anger*" and "*why*", and feeling "*dismissed*" and "*not respected*".

7.3.3.2 Participant 032 post-therapy interview (032-2)

The post-therapy interview consisted of the following themes: Continuing stress at work counterbalanced by a happy home life with a new relationship. Here there was a sense of "*Looking forward. Future*". An image of a Buddha was used to represent yoga and meditation. A long road with a stick figure at either end indicated continued difficulties communicating with her sister, and the words "*Worried about Mum*" were present. An image of a Sergeant's badge represented continued difficulties from the past around her father. The group of faces connected to this represented the counselling skills course which was helping her to deal with this. The course, in combination with the new relationship, seemed to be the primary change factors, with the participant reporting that the counselling had not helped at all.

7.3.3.3 Participant 032 follow-up interview (032-3)

The follow-up life space map was more 'wordy' than previous maps. Themes included "*Communication for better*", an image of a house with the words "*Very Good*", linked to "*Partner, I V.happy*", "*Work better. May move work, no longer No 1, Less available*", "*Some respect back for me*", "*Mum*" feeling "*Stronger*" and more able to "*cope*" with the inevitable loss, "*Stress*" still present at work, but "*Now still being good to me*" and "*Holiday*". These were underscored by the themes of "*More in control of everything, Work to live, Be good to me*". There was a sense of ongoing learning from the counselling course, that she had continued to gain self awareness and insight from this, and was more able to see old habits and change how she reacted to things.

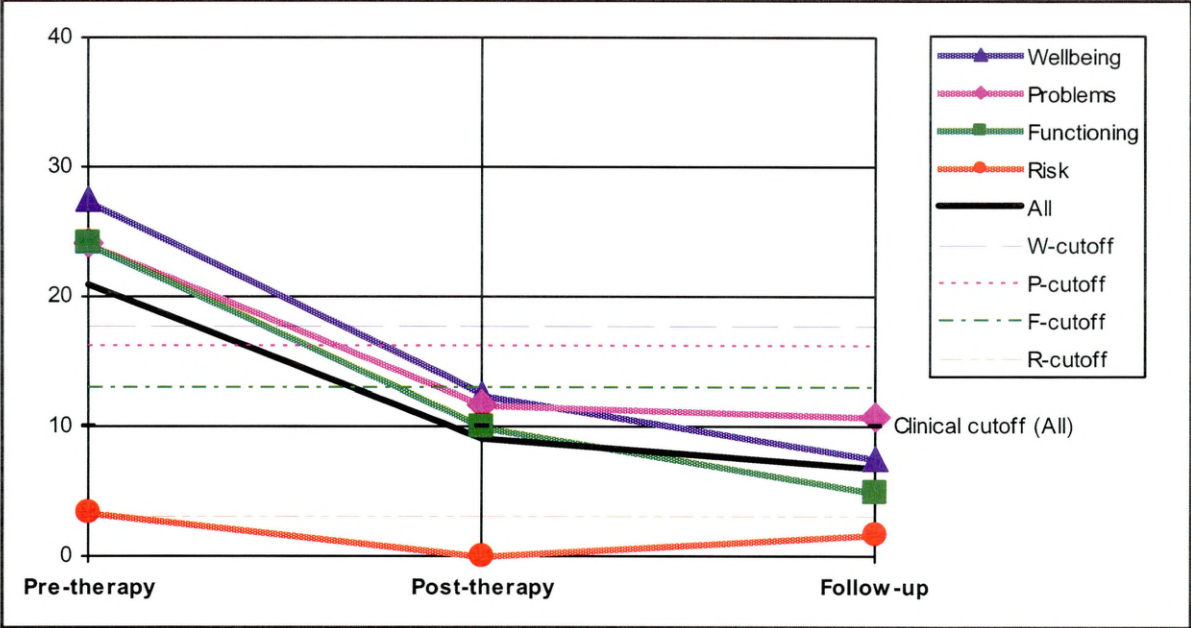


Figure 7-11 Participant 032 CORE-OM graph

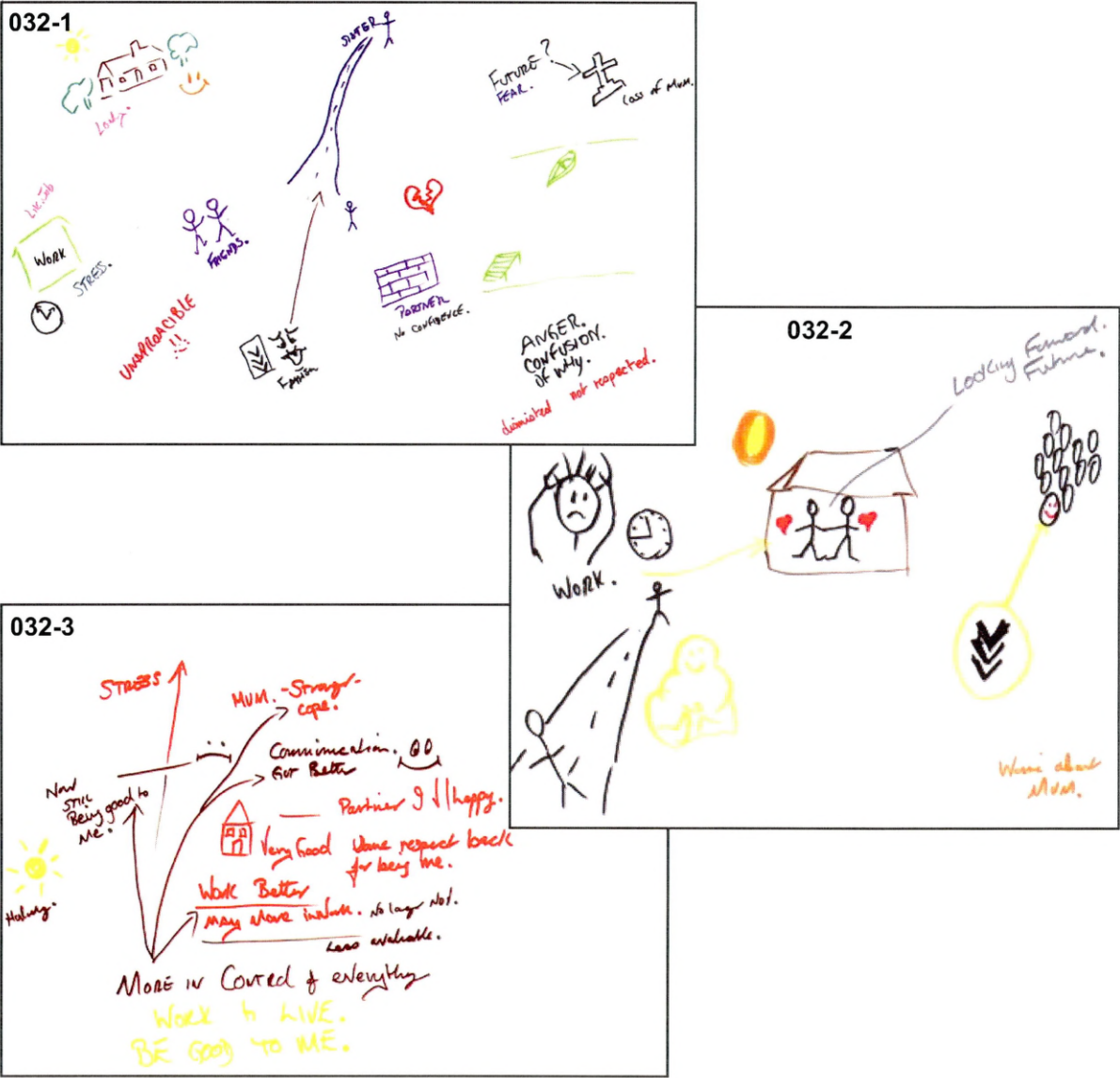


Figure 7-12 Participant 032 Life Space Maps

7.3.4 Participant 033

Participant 033 was a 49 year old female who attended for 27 sessions of counselling for depression. Only two interviews were conducted due to the time constraints of the data collection phase of the study. This participant demonstrated clinically significant and statistically reliable change on the CORE-OM from pre-therapy (mean score 27.35) to post-therapy (mean score 9.12). Her Life Space Maps generally consisted of very abstract images with few words.

7.3.4.1 Participant 033 pre-therapy interview (033-1)

During the pre-therapy interview, this participant was in quite a 'raw' place, saying "*I know I've needed help a long time*". She revealed a history of a previous psychotic episode and suicide attempt, and that all previous assistance she had sort had not really helped. The Life Space Map she created during the interview was very succinct and abstract. The following extract from the interview captures the essence of this:

It feels quite demanding, and quite emotional... I feel, because it's intimate... I'm inclined to go for black and to make a shape more than words... or even choosing colours. Black would represent the dark side... but there is like highlights... the joys of my Grandson... he takes the black away... he brings in colours... sometimes they are flashing and bright... red and orange... If it's not black then it's more of a purple colour... Then I take these quite negative feelings... that I would be better not here, and then I get this black dark place again...

7.3.4.2 Participant 033 post-therapy interview (033-2)

During the post-therapy interview, this participant drew two drawings on separate pieces of paper, again quite abstract. In one, the words "*Getting there – knowing what it is and how to achieve it*" appear. Seeing her pre-counselling LSM had quite a lot of significance for this participant. She saw that "it's almost as if I'm being crushed" – that the colours on the inside were her 'life' and the dark areas either side were crushing her, draining her of energy. From attending counselling, this participant felt they could now put things into perspective better, that she no longer felt debilitated and was "up and running" again. There was a sense of really being in a different place which she could clearly see from the LSM, and was also very noticeable from the CORE-OM results graph. For this participant, it was very significant for them that they had dropped below the clinical cut off line. This really made an impression in terms of the feeling of having come a long way in a relatively short space of time compared to the years of suffering and turmoil she had experienced previously.

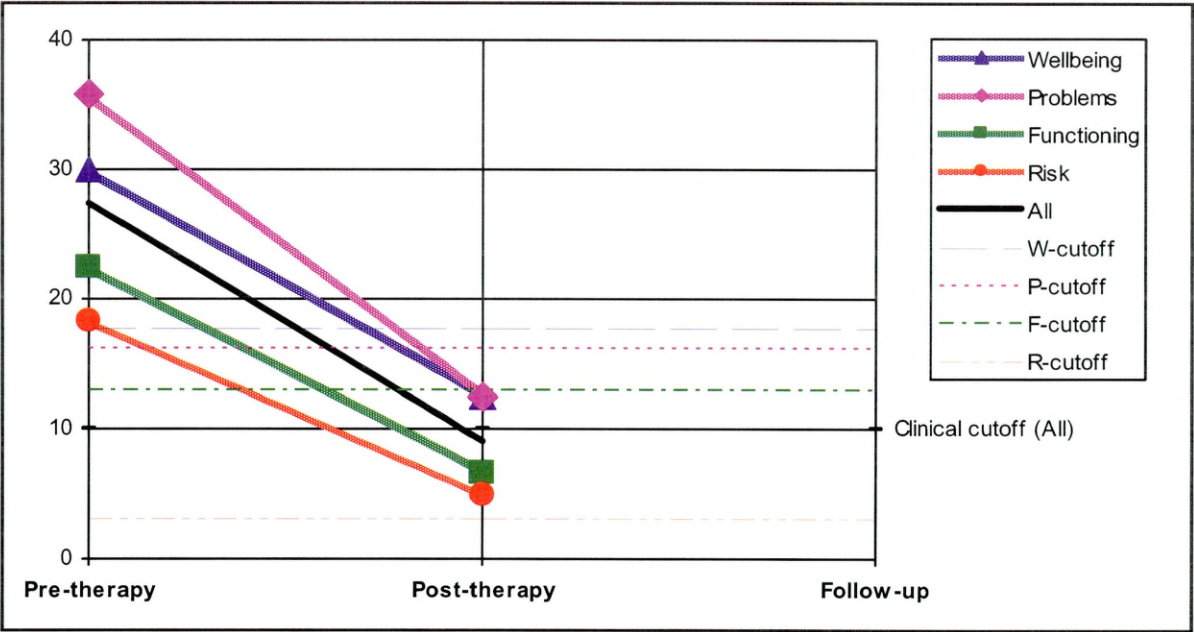


Figure 7-13 Participant 033 CORE-OM graph



Figure 7-14 Participant 033 Life Space Maps

Participant 037

Participant 037 was a 41 year old male who attended 3 sessions of counselling for anger management. This participant demonstrated statistically reliable change on the CORE-OM from pre-therapy (mean score 8.82) to post-therapy (mean score 2.94), but not clinically significant change as they did not start in the clinical range. The gains attained at post-therapy were maintained at follow-up (mean score 2.94).

7.3.4.3 Participant 037 pre-therapy interview (037-1)

During the pre-therapy interview, the participant constructed a fairly standard ‘node link’ style map with words in circles linked to a central hub. The nodes of this map included “*Work: Pressures of work-2*”, “*Desire to succeed-3*”, “*Home: Pressures at home-4*”, “*Anger-5*”, “*Children: Walk away*”, “*Gym: Exercise*”, “*Perfectionist / Untidiness*”, “*Verbally abusive / Throwing things*”, and “*Driving: Verbally abusive*”, with the numbers indicating the sequence of events. This participant reported that he was alarmed at how angry he became over small things, and that this was progressing. He could see that his father had been an angry man, that his son was becoming an angry young boy, and that he just didn’t want to be like that anymore.

7.3.4.4 Participant 037 post-therapy interview (037-2)

The post-therapy LSM consisted of a pie chart with the following segments: “*Family-1: Married since last meeting*”, “*Work-2: Very busy at present*”, “*Social Life: Been on honeymoon. Been out regularly. Am going on holiday.*”, “*Hobbies: Have been attending gym. Been playing five a side football*” with the numbers indicating priorities in life. The participant reported that since the last interview, he had made a point of restraining himself and removing himself from situations which made him angry, and that this had happened “*out with the help of the counselling*”. Here there was a sense that the counselling had not fulfilled his expectations, that the changes he had noticed were more of his own making, and that he still had work to do in order to make things ‘stick’.

7.3.4.5 Participant 037 follow-up interview (037-3)

The follow-up interview consisted of constructing a bar graph indicating how happy the participant was in different areas of his life with the following key: “*1- Family*”, “*2 - Work*”, “*3 - Social*”, “*4 - Relationship*”, “*5 - Ability to cope during tense situations*”. Here his ability to cope with tense situations was still somewhat of a cause for concern, and there had been a few instances since the previous interview that he had lashed out verbally. There was a sense of not really getting anywhere, of not knowing a way forward. However, he had recently enrolled on a forthcoming anger management course that he hoped would be more focused than the counselling on the problems he was trying to resolve.

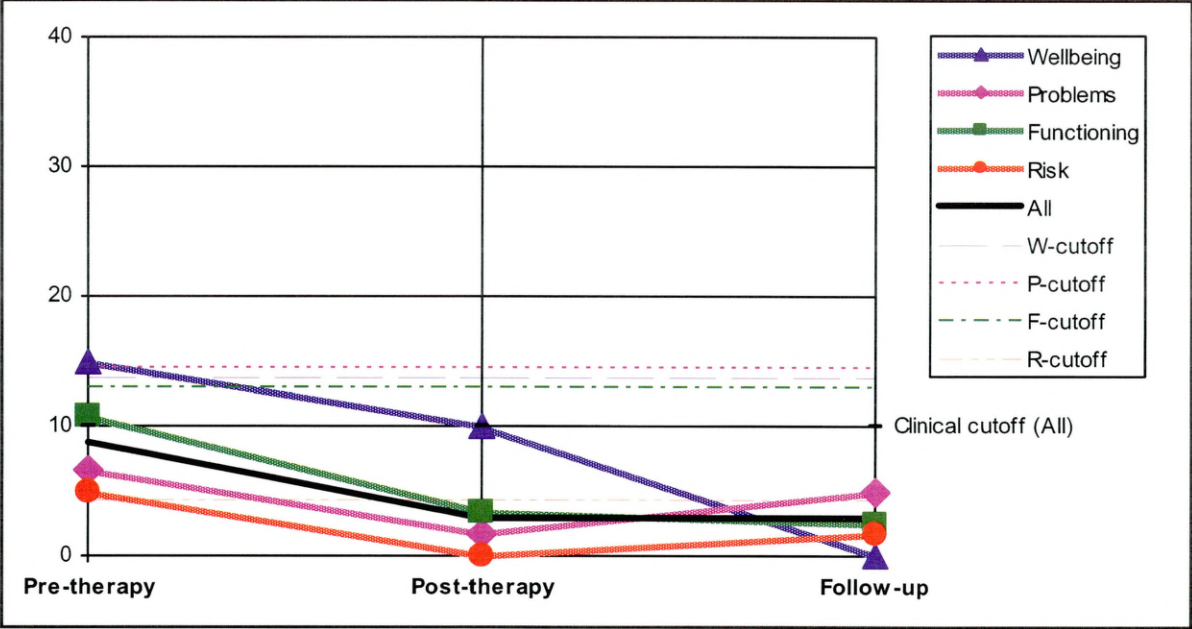


Figure 7-15 Participant 037 CORE-OM graph



Figure 7-16 Participant 037 Life Space Maps

7.3.5 Participant 043

Participant 043 was a 26 year old male who attended 33 sessions of therapy for depression. Only two interviews were conducted due to the time constraints of the data collection phase of the study. This participant demonstrated statistically reliable deterioration on the CORE-OM from pre-therapy (mean score 24.41) to post-therapy (mean score 29.41). His Life Space Maps looked strikingly different from pre-therapy to post-therapy, with the pre-therapy map using a fairly standard 'node link' style of words in circles, while the post-therapy map was much more graphical and evocative. Though this participant felt they had gained a lot of self awareness from the counselling sessions, he had to stop coming for therapy because of a new job which made it impossible to attend. As such, there was a sense of 'unfinished business' about this case.

7.3.5.1 Participant 043 pre-therapy interview

The 'node link' style map constructed during the pre-therapy interview consisted of the following words: "*Work*", "*Home*", "*Mum*", "*Dad*", "*Girlfriend*", "*Relationships*" in the middle, "*Reading*", "*Film*", "*Music*" on the left, and "*Isolation*", "*Solitude*", and "*Confidence/Depressed*" on the right. The red surrounding some of these words was used to represent anger or being "pissed off". During the interview, this participant related that he tended to bottle things up, that he was quite guarded and did not communicate well, especially with his parents. He also reported getting quite anxious, especially when he was on his own, and that he had thought about things like self harm or taking drugs, but knew at the heart of himself that he couldn't be "that stupid". He had been on antidepressants for the past four years which did not seem to be doing anything for him, so in the last few months he had been looking for alternative help, including seeking counselling.

7.3.5.2 Participant 043 post-therapy interview

Though the Life Space Map created during the post-therapy interview looked visually very different from the pre-therapy LSM, for the participant they seemed to tell pretty much the same story. For him, the same core problems still remained, though he had a different way of looking at them. "*Parents*", "*Friends/Relationships*" and "*Work*" were again present, but this map also prominently revealed "*Harming myself*" as well as a sense of being directionless in the words "*Dead end*" and "*Nowhere*". "*Communication*" was surrounded with question marks and the word "*Past*" was repeated around the central image. In terms of actual change, this participant felt they were pretty much the same as when they started counselling, but felt freer to talk about the things that were bothering him. This was very apparent both in the CORE-OM score and the content of the LSM, both of which 'looked' worse, but which the participant revealed was more to do with being more honest and transparent during the post-therapy interview.

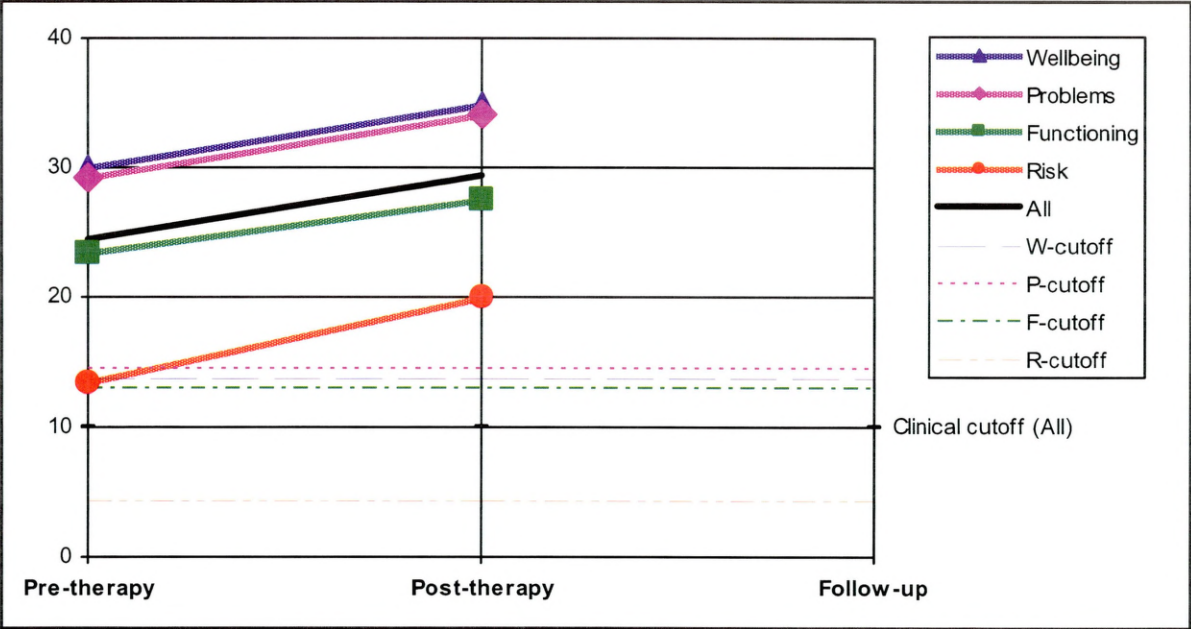


Figure 7-17 Participant 043 CORE-OM graph

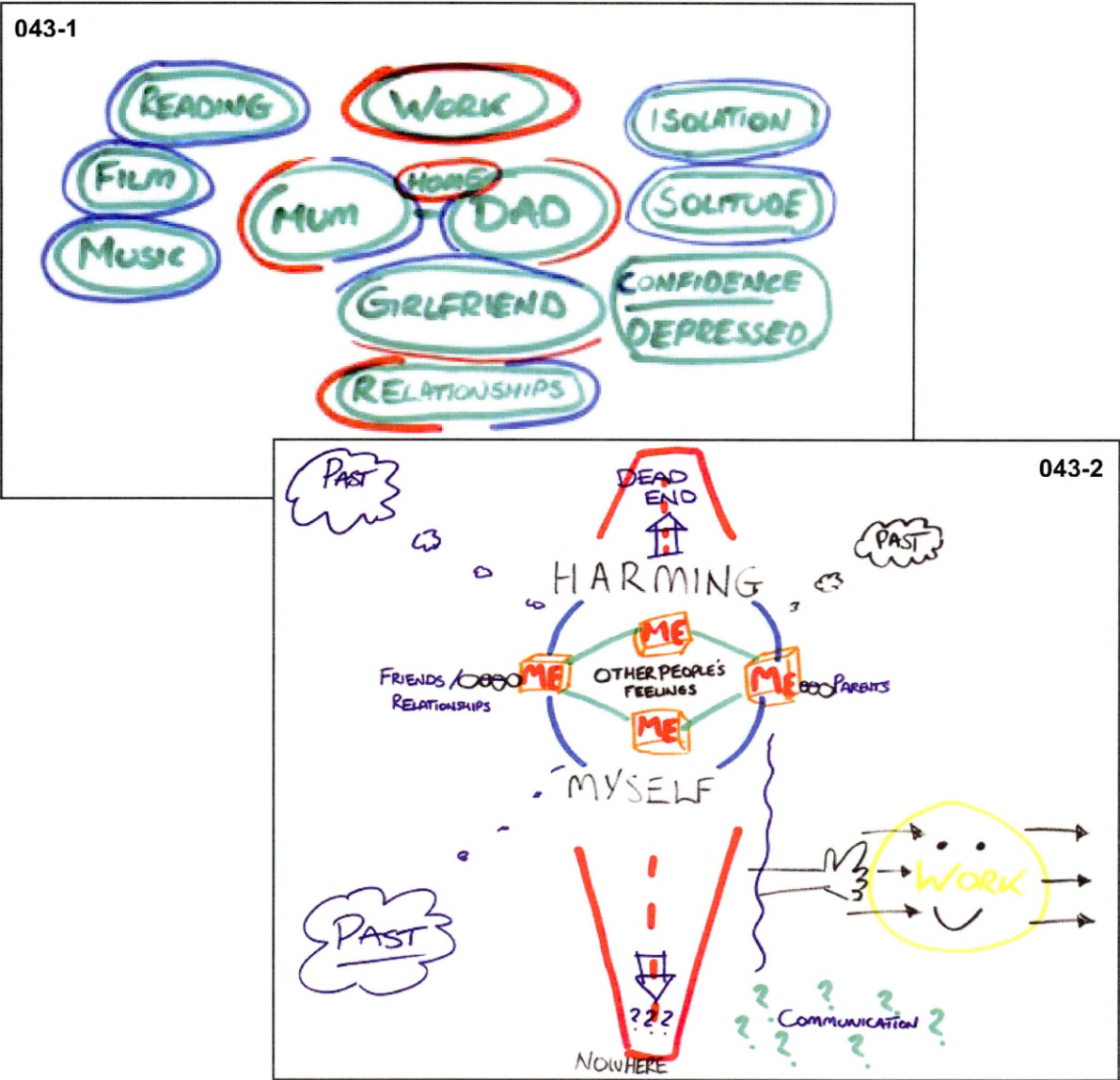


Figure 7-18 Participant 043 Life Space Maps

7.3.6 Montage summary

This montage of Life Space Maps and CORE-OM graphs reveals a number of key results in terms of the aims of the current study:

- Life Space Maps can provide a highly evocative and personalised visual representation of change over the duration of therapy compared to the CORE-OM graph.
- Clients construct Life Space Maps in highly idiosyncratic ways ranging from very structured ‘node link’ style maps and graphical drawings, to extremely wordy accounts and ‘letters to self’, to detailed pictograms combined with brief words, to highly abstract representations with no words at all.
- The style of Life Space Map that any one person uses may remain fairly static over time or may change significantly from map to map.
- The idiosyncratic nature of Life Space Maps means that they can be difficult to interpret accurately without at least a brief contextualising narrative from the client.
- The CORE-OM graph provides an instant and definitive indicator of improvement or deterioration which is not usually possible looking at the LSM in isolation.
- The CORE-OM graph provides a mechanism for directly comparing cases on a ‘like for like’ basis which is not possible with the LSM alone.
- Neither the CORE-OM graph nor the LSM in isolation give a ‘full’ picture of change. To get the fullest understanding of outcome for a client requires a combination of CORE-OM data, Life Space Maps and contextualising narrative.

7.4 Part 4: Thematic analysis of participants' experiences of using the LSM and CORE-OM

When asked to compare the different methods and their experience of completing them, participants related a number of themes. Each theme has been classified in terms of relating an experience to do with either the CORE-OM or the LSM. These themes have then been grouped into categories which highlight the 'dimensions' or opposing 'poles' of people's experience of using the CORE-OM and the LSM as a method for assessing the outcomes of their therapy. The intent here is to emphasise the potential differences along these dimensions, rather than portray individual experiences. As such, the following themes and categories are not intended to *represent* the participants' experiences, but rather to construct a form of *typology* of their experiences which can be used to contrast and characterise the two methods. Hence the results are not presented with indicators of density or frequency of response, but rather with brief quotes from participants which capture the essence of each theme. No one individual reported all the themes to the degree they are portrayed below, while some themes were expressed only minimally by the majority of participants. Taken as a whole, however, the themes below 'flesh out' the differences between the two methods, and allow them to be contrasted and compared along the dimensions of "external versus internal reference schema", "cognitive/rational versus creative/irrational task", and "linear/static versus nonlinear/dynamic process". Note that some of the themes below could have been included in more than one category. For clarity of presentation and conceptualisation however, it was decided to include themes under a single category which represented a 'best fit'. However, the descriptions of the categories themselves have been shaped by the total analysis, and as such do contain a flavour of these cross related themes, even if not explicitly referenced.

Participants were also asked to relate the relative ease of use along with the effectiveness of the CORE-OM and LSM for evaluating the changes they had experienced throughout the duration of the study. The results of this analysis are presented after the thematic analysis of the dimensions of people's experience of the CORE-OM and LSM.

In the following write up, direct quotes from participants are included to give a flavour of people's own words. These are prefixed by the participant number and stage of interview, such that participant 1's pre-therapy interview would be indicated by (001-1) while their post-therapy interview would be indicated by (001-2) to denote their second interview. The researcher's words are enclosed in square brackets "[...]" while implicit references (e.g. to the CORE-OM or LSM) are enclosed in curly brackets "{...}".

7.4.1 External versus Internal reference schema

One of the key dimensional differences between the methods used was the externalised nature of the CORE-OM versus the internalised nature of the LSM. This dimension represents the difference between a person looking outwards for a frame of reference in order to relate their problems or concerns and the changes they have experienced versus looking inwards to their own internal reference point.

The CORE-OM as an external reference schema	The LSM as an internal reference schema
Checklist of problems/changes	Puts you more in touch with your feelings
Realising problems are quite common	I'm in control – allowing things to emerge
Makes you 'check in' with yourself	Makes things more tangible
Objective confirmation – so I don't just feel it	Makes you 'break it all down'
Comparison to 'average' person significant	Takes you back – like a photocopy of the brain
Too general – not relevant to me	Hard to 'put it onto paper'
Items scored differently from their intention	More to it than meets the eye
Covering up how bad things were	

Table 7-15 Summary of codes for internal versus external reference schema

7.4.1.1 The CORE-OM as an external reference schema

Generally, the CORE-OM requires people to engage with an external reference schema. A questionnaire item is seen, then taken in to 'check' it out (like in a check list), then responded to in terms of fitting in to an appropriate 'box'. This is largely a 'reactive' process where people are presented with an external stimulus and are asked to react to this. From a participant's perspective, this process can be quite affirming in terms of giving people an opportunity to see that what they are experiencing is quite common, that other people have experienced similar problems. It can also potentially introduce new thoughts or view points which a person may not have previously considered. A further benefit of this external reference schema is that it allowed participants to compare their own inner sense of change with an 'objective' measure, something which was not just their own view. Additionally, it gave a common point of reference in terms of the clinical cut off scores against which a person could compare themselves. This had an overall function of reaffirming a person's own inner feelings of change with a more tangible external indicator. On the other hand, some participants experienced the CORE-OM as being too general, that the questions did not really capture a sense of their specific problems or issues. Further, some people misinterpreted the items on the questionnaire such that the responses they gave were opposite to that expected from the external scoring schema. Finally, there were also occasions when participants acknowledged that they had artificially responded to some questions in order not look so bad. There is a sense here of the external schema not quite fitting for people, of it misinterpreting the individual in a number of ways, or of creating an expectation of how the questions 'should' be responded to.

7.4.1.1.1 CORE: Checklist of problems/changes

Participants were able to use the CORE-OM as a checklist of their problems, and the changes that had occurred. It can be seen as a list of commonly experienced issues that people are able to recognise and compare themselves against. This was experienced by some as quite an affirming process as the person went down the ‘checklist’ and realised they did not score highly on some things, or had moved from their original score.

(014-3) *“Have I thought of hurting myself”... that sort of thing is not on the cards... “Talking to people has felt too much for me” – well just before I came here I started to realise that that was quite a major thing for me, but it wasn’t a thing I had actually thought about.*

(032-2) *“I have thought it would be better if I were dead” – ‘Not at all!’ I’ve never thought it was better if I were dead. So in some way it gave you a wee bit of a strength to work on, even if you are feeling totally “oh my God, I’m deflated, I don’t have one more ounce of energy left in me, do I need to fill in this questionnaire... actually, no, it isn’t better if I were dead”... So it gives you an idea that there’s a level you are at, that you can maybe build on, not totally washed out or finished.*

7.4.1.1.2 CORE: Realising problems are quite common

Seeing their problems on a ‘standard’ questionnaire can make participants realise that their issues are not unusual, that other people must feel the same things. This had a sense of making a connection with others, of not feeling so isolated or ‘different’ from everyone else. There is also a sense here of giving words to people for what they are feeling, that the items on the questionnaire ‘give voice to’ commonly experienced problems and difficulties.

(006-2) *Some of the questions about anxiety just made me realise that it is quite a normal thing, that people do suffer from it... that some of the things that do apply to you, you realise that other people do suffer from that... Sometimes when you feel quite isolated... you do feel completely alone, and maybe quite self indulgent, you think no one else has ever gone through this, or no one else thinks the same as me, or maybe I’m just really awful, or people can just cope better... Sometimes when you read things like that {CORE} you realise that it is [normal].*

(041-1) *It’s bringing it out, it’s actually seeing it written down on paper, actually seeing what your feeling, it’s bringing it out. You can actually say right, this is how I’m feeling, and you can’t really explain how you are feeling to anyone else. So I think that is good with the questions because it actually brings the things out of you.*

7.4.1.1.3 CORE: Makes you ‘check in’ with yourself

The specific questions in the CORE-OM gave participants an opportunity to ‘check in’ with themselves, to actually stop and think about things that they may not really have considered previously. There is a sense here of using the questionnaire to initiate an internal dialogue to see if the items ‘fit’ for a person or not. There is also a quality of challenging a person to “face up” to things, to be really honest with themselves.

(002-3) *Have I felt okay about myself? – I’ve never really questioned that about myself... I’ve never really questioned that... I’ve got to ask these questions... am I coping? Whereas before I never questioned anything...*

(032-2) *I think there was... “I’ve threatened or intimidated another person”, I’d loved to have said ‘not at all’, but the honest truth is “only occasionally”. It has happened occasionally, that’s the feedback I’ve been given... It didn’t feel nice to have to admit things like that, but this type of thing doesn’t work unless you are honest... For me, ticking it is facing up to being honest about that I’ve got issues and problems that’s made my life unhappy... I’ve done that, and I need to face up to the fact... It makes you really think about it...*

7.4.1.1.4 CORE: Objective confirmation – so I don’t just feel it

Participants saw the CORE-OM as an objective confirmation of their own sense that things had changed. There was a sense of affirmation here, of giving people a chance to see definitive change from an external perspective, that it's not just the person themselves that thinks they have changed.

(001-2) So I don't just feel it, it's... Well, I felt that I'd benefited from the counselling, so that indicates that I have. But I felt that I had, I'd felt that it had come to an end. It wasn't {the counsellor} that said this is enough. I just felt that, probably the second time, well probably the last time, I felt a bit of a fraud, I was using up her time when somebody else could have more need of it... But that confirms that I possibly improved which is good.

(032-3) It's confirmed in writing that I am on the road to a better life, or recovery. I can say that I feel better in myself, and I can go and tell people how I think and feel now, but they might go "oh, all right, you seem a bit calmer"... but sometimes I worry that I kid myself on and that I'm thinking "am I saying this to hopefully make myself feel better" or is it actually happening, do I feel it. So when you reflect back to how I was answering questions then to how I'm answering questions now, it is absolutely totally clear that there has been a progression and things are getting better...

7.4.1.1.5 CORE: Comparison to 'average' person significant

Participants saw the change in their CORE-OM scores relative to the clinical cut off points as significant. This seemed to have real meaning for people, to be able to compare their mental state with some 'objective' indicator of psychological wellbeing.

(019-3) I remember last time being secretly really delighted that I'd come down so much... not to say there is a 'normal' that we should all be based on these answers, but it was just nice to think that I wasn't in a danger zone I suppose, or in a place where my mum would worry about me, or in a high risk area I suppose. So now to see myself completely under it, and generally in every area that bit better, it's quite...

(033-2) It has had a big impact seeing it like that, especially this line here [the clinical line] it seems to be quite... I keep coming back to it. I feel as if I've passed a test with honours {laughs} honestly, I just haven't got the pass, I've got a wee bit more...

7.4.1.1.6 CORE: Too general – not relevant to me

At times the CORE-OM was too 'broad spectrum' for participants. It covered a very general sense of the person but was not individual enough to really get at their unique situation. As such, there was a sense of people feeling 'missed' by the questionnaire.

(006-2) The questionnaire is general, its 34 questions, and you're speaking to all different kinds of folk that have all different problems... I understand that you can't really capture someone's personality... Some of the questions weren't really relevant to me but I know it has to be really general... I've never had a problem with violence, I've never felt violent to anyone... I know that it's just a general thing, and it's just some people that it applies to and stuff... because everyone has different problems.

(019-3) In the context of this it makes sense. In fact filling it {CORE} in today, I even thought I can see the value of this because you can... it does give you some outcome... you can also draw conclusions... but it is a fraction of a human being, it's such a small fraction.

7.4.1.1.7 CORE: Items scored differently from their intention

Participants interpreted a number of CORE-OM items differently from that which was intended by the questionnaire designers. Here people responded to the questions in a way opposite to that intended by the external scoring schema. For one participant, almost all the positively worded items of the CORE-OM were initially interpreted "back to front" until checked out by the researcher. This would have resulted in the total score being significantly higher than it should have been.

(006-2) *["I have felt able to cope when things go wrong" – You've put 'only occasionally'] Yeah, I think I should have put 'often'. Yeah, as I said, sometimes I do feel anxious but not to the same degree as before. So I do kind of think, 'Oh no, what if this happens, what if that happens' – but I do kind of talk myself through things... But I don't worry about things as much as I used to... [With the before one {pre CORE} you've put 'sometimes', so this is saying you're less able to cope]. No, I wouldn't agree with that. I should have ticked the other one...*

(040-2) *I think I filled that form in wrong – back to front. "I have felt okay about myself", it should be the other one, the other end. 'Not at all' I just read that as negative. I should have put 'Most of the time'. It's the grammar of it. "I have been happy with the things I have done" – same again. [When you were reading that, was it like "Have I been unhappy about things that I have done?" – 'not at all'] Ah huh. "I have felt warmth and affection for someone" – same again. Definitely it's the other end [There are three more there as well, I just want to check them out] Yes, they should all be at the other end.*

7.4.1.1.8 CORE: Covering up how bad things were

Looking back at their initial CORE-OM responses, some participants could see they had not been completely honest, that they had 'covered things up' at the beginning to put on a better 'face'.

There is a sense here that the CORE-OM can be seen as something that will be used by an 'expert other' to make a judgement on a person.

(019-2) *I think when I did this {CORE} last time, I had a memory of doing it for a counselling session in London, and a sense that if I gave certain answers then someone would add up all these numbers and conclude that I was this type of personality disorder, or this type of problem. Now that I feel a bit better it doesn't worry me so much. [Was that a little bit around when you filled it in the first time, that it could be used to judge you?] Possibly yeah, I didn't have it so much here but when I went to see my psychologist I was so terrified the first time that I was going to fill in all these forms, he'd look at them and then go, "right you are schizo affective disorder" or you're this or you're that.*

(043-2) *"I have been disturbed by unwanted thoughts and feelings" – at the time {pre CORE} I put 'sometimes' but I was actually a little bit surprised that I only put sometimes. I don't think I was maybe being as honest. "I have made plans to end my life" – at the time I put 'not at all', again I don't think I was being honest because, not knowing what would happen when I came here... I was still afraid of talking about something like that at the time. I kind of get the feeling that I was probably a bit too scared to write it down, being totally honest.*

7.4.1.2 The LSM as an internal reference schema

In comparison, the LSM requires people to engage more from an internal reference schema. This is more of a 'reflective' process, where rather than reacting to a set of pre-defined external stimuli, a 'blank canvas' is confronted, onto which a person is required to initiate their response. From a participant's perspective, this was experienced as an opportunity to get in touch with their feelings more fully. Here there was a sense of things 'emerging' for a person, of being given a space to see what is there. For some this was a positive experience but for others it required 'facing' what was troubling them. This process allowed things to become more tangible for a person, rather than just 'being in their head'. It also required people to go through a process of differentiating things, of breaking things down so that it could be represented on paper. In terms of reflecting on change, there was a sense of people being 'taken back' to how things were, to see why they had come to counselling in the first place. Here there was a real sense that the LSM provided a very evocative and individualised reference point for people to reflect on, as one participant put it, like a "photocopy of the brain". Though valuable when completed, a number of people reported that it was quite challenging to construct as there was no external reference point to begin from.

Significantly, a number of participants also identified that the specific meaning behind their LSM was often hidden from view and not obvious from an observer perspective. As such, the interpretation of the LSM needed to go hand in hand with a person's own commentary rather than in isolation.

7.4.1.2.1 LSM: Puts you more in touch with your feelings

Doing the LSM gave participants an opportunity to get more in touch with their feelings. There was a sense here that in the process of creating the LSM, people took the time to get in touch with the way they were feeling which they may not have done before. This could be both beneficial and also a difficult process, with participants 'touching' on things that might be quite unsettling.

<i>(006-2) I suppose it's just expressing how you are feeling, but also it can make you realise... how sad you are in a way... I suppose it does put you more in touch with your feelings...</i>
<i>(020-2) That {pre LSM} was horrendous... That even had an effect on me that night when I went home, just remembering... because I think that forced me to look, to see the mess I was in. It brought a lot of feelings up. I'd been thinking about the picture, because I didn't really sleep well that night, thinking about the feelings that it brought up... futility, anger, frustration...</i>

7.4.1.2.2 LSM: I'm in control – allowing things to emerge

The process of constructing the LSM allowed participants to express as much or as little as they wanted to. People did not feel forced to respond more than they did. There is a quality here of providing a space to see what naturally 'emerged', rather than having a predefined agenda, or a 'fixed' set of things to respond to, or being forced to say something out loud.

<i>(014-2) Even though it's {LSM} quite an emotional process I'm in control, whereas I'm not in control of that {CORE}... Even though I'm being quite honest there {LSM} I can still be a wee bit... [like you're in charge of how much or how little you put down] uhuh... whereas there is no control in that {CORE}. Like there is a question, and there is an answer, and there is not much in between.</i>
<i>(032-1) It was probably easier to draw pictures than... if I had had to sit and actually just say the words, I probably would have broke down or got upset because I'm feeling emotional just now. But it was easier to just not say anything and draw the pictures, than to have to go through a list of feelings that I feel and say it verbally.</i>

7.4.1.2.3 LSM: Makes things more tangible

Participants reported that seeing their LSM made things clearer and more tangible for them, that the process of putting things down on paper made things more 'real' for them rather than it just being all in their head.

<i>(014-3) It's also making things a bit more real as it were because you've got things happening in your head but when you put it down... it's a lot more real [it's there, you can see it, it's not just something...] flapping around in your head. More colour to it, more depth to it...</i>
<i>(033-1) I think I was maybe getting it across to myself, in seeing it for myself. Actually doing that has made a bit more sense to me now.</i>

7.4.1.2.4 LSM: Makes you 'break it all down'

The process of constructing the LSM required participants to break their problems and issues down so that they could be put onto paper, rather than everything being mixed up in a big 'haze'. This process allowed people to see things more clearly, to differentiate things for themselves.

(003-2) *Breaking it down allows you to separate it... and also allows you to look at... once you've separated how you feel about certain things you can see what the positive things are in your life and work on that as opposed to thinking everything is bad... Because when you've got so many different feelings about so many different things it's easy to mix them up and everything just becomes a big haze. So looking at it like this breaks it all down and makes it easier to realise that right, okay I've got that problem at that side, and that problem on that side...*

(043-1) *At first I didn't have a clue what to write, just didn't know what to put down, because I've never done anything like that before. But actually as you start it, you start seeing the different things that are getting to you... You can see a lot of things...*

7.4.1.2.5 LSM: Takes you back – like a photocopy of the brain

The pre-therapy LSM really captured for people how things were for them before their counselling began – like a photocopy of the brain. It took people back to how they were feeling at the time and reminded them why they came to counselling in the first place. There was a sense here that because a significant amount of time may have elapsed for some participants, they had almost forgotten how bad things were before their counselling, and the LSM was a vivid reminder. Though valuable for reflecting on change, this also had the potential for bringing back some of the difficult feelings that were around for people at the beginning of therapy.

(008-2) *Because somebody would come in here if you didn't have that and you'd burnt it or shredded it. Would they really remember it the way it is now? I don't think so – "I can't remember it. Was I really that bad?" But that's a photocopy of the brain at the time as far as I'm concerned... That's how you're feeling at the time.*

(021-2) *It gives a bit of a... {taping heart} it gets in there a wee bit, it can get in to some of the feelings of where I was at within there {pre LSM}, so yes, there's a bit of 'uh' in there. I think I've come a long way, but I'm also aware that I'm a bit wobbly in places.*

7.4.1.2.6 LSM: Hard to 'put it onto paper'

Participants found it difficult to know where to start drawing their LSM. There can be so many things going on for someone that to actually begin the process of 'putting it onto paper' can be quite daunting, especially given a 'blank canvas'.

(017-1) *At first, I didn't know how to put in on to paper, I felt a bit confused – "I don't know actually what to do here"... I would have liked to have drawn something, but you just feel as if you don't know, you could be just drawing a lot of rubbish, because it's just confused feelings, you'd just put it down totally wrong...*

(032-1) *I've never expressed myself in drawings before so that makes me wonder where to start... just trying to put things into pictures, because I've got all the things in my head like family, friends, work, all these different things that are related in my life but trying to put them into pictures is difficult...*

7.4.1.2.7 LSM: More to it than meets the eye

Participants reported that the meanings embedded in the LSM are not necessarily explicitly obvious at face value. There is often a lot of hidden meaning behind the LSM that can only really be understood by the person constructing it. To fully understand the significance of an LSM, it needs to go hand in hand with a person's own commentary to really begin to understand what has been depicted.

(001-3) *I know what I've written down here {post LSM} is enough, but it probably isn't enough for you... my brain is going faster than my pen, and when I re-read it I haven't written half the stuff down. [So in this case, that {post LSM} has a lot more meaning to you than it does in the actual words?] Yeah...*

(014-2) I don't feel that I've conveyed everything on the page, the visual aspects. I think I needed to have a commentary on that... apart from anything else there is no way you would be able to look at that and say 'oh yes, this is what she got out of the counselling sessions'. [It needs to go hand in hand with the dialogue, the commentary] Oh yeah.

7.4.2 Cognitive/Rational versus Creative/‘Irrational’ task

This dimension represents the difference between a person engaging in a cognitive or rational task versus a more creative or ‘irrational’ approach to relating their problems and issues, along with how these change over time. Here, the CORE-OM is typically a more cognitive process which requires a person to relate their problems and issues in a rational manner. In comparison, the LSM engages people in a more creative way, allowing a less rational expression of problems and issues.

The CORE-OM as a cognitive/rational task	The LSM as a creative/‘irrational’ task
Like doing multiple choice	Uses a different part of the brain
Debating with yourself – difficulty fitting into a box	Imagery 'speaks' directly to you – hits you in the face
A ‘technical’ thing which needs interpretation	Like a film of your life
An ordeal - Like asking you to run a marathon with a broken leg	Difficulty being expressive
	Quite child like

Table 7-16 Summary of codes for cognitive/rational versus creative/irrational task

7.4.2.1 The CORE-OM as a cognitive/rational task

The CORE-OM requires people to engage primarily in a cognitive and rational task. The various markings and shapes on a sheet of paper are required to be ‘cognised’ as numbers, letters and words from a specific language. These are combined in a logical and coherent manner to form sentences which relate a specific concept or idea. These then need to be responded to using a numeric scale which requires a person to ‘rate’ themselves against predefined anchor points. This whole task is quite cognitively advanced, with a significant level of abstraction between the actual markings on a sheet of paper to the concepts which they relate. For example, these concepts could potentially be related in a different form (e.g. a different language, using Braille, spoken out loud or using sign language) without a significant impact on the way they were interpreted. From a participant’s perspective, this was experienced as a familiar social task of ‘form filling’, in particular, of doing ‘multiple choice’. Most participants found this fairly straight forward, however some had difficulty fitting themselves into a box. In terms of looking at change, there was potential here for the magnitude of change to be misrepresented. The CORE-OM was also experienced as quite ‘technical’ in that the differences between scores along with the meaning of the results graph needed to be explained and interpreted. For participants struggling cognitively, the whole process of completing and understanding the CORE-OM could feel like an ordeal. Here the analogy used by one participant was of asking someone to run a marathon with a broken leg, that when your thinking is ‘broken’, it could be quite distressing to have to engage in a relatively complex cognitive task.

7.4.2.1.1 CORE: Like doing multiple choice

Participants recognised the CORE-OM as being similar to doing multiple choice questions. There was a familiarity with this process which made it quite clear what was required of people. Overall, this was experienced by most participants as a fairly straight forward task.

(001-3) *I think the questionnaire makes it a little bit easier for you. It's a multiple choice question type of thing. It's easier to tick something than put your thoughts down on paper. It was easier to fill that {CORE} in.*

(017-2) *It's just because it's a tick, it's like a multiple choice, I feel it's very easy to do, it's an easier thought process to do than actually concentrating on that {LSM}. It's a simpler task to do... there's enough categories there, 0 to 4 is fine. I found it pretty straight forward...*

7.4.2.1.2 CORE: Debating with yourself – difficulty fitting into a box

Sometimes participants felt it was not quite so straight forward to put themselves into a particular box. People had to 'debate' with themselves as to which 'box' to put themselves in. Here the anchor points on the Likert scale of the questionnaire seemed to be quite non-linear and vague, leading to different interpretations of their meaning. There is also a sense here that a one point shift between pre and post scores could easily either over or under estimate the actual change.

(014-2) *It's sometimes quite difficult to... the differences between 'I have felt despair or hopelessness' and I've been debating whether to go 3 or 4 and I went for 4... and it's probably the same ones I've debated it... the ones that I'm different, I've gone for the same two and debated most of the cases...*

(019-2) *It's again that difference between 'not at all' is never, 'only occasionally' it could happen once or twice for 5 minutes, 'sometimes' you feel like it's happening 50% of the time perhaps, so if I said "sometimes I've felt terribly alone and isolated" that's potentially 50% of the time, whereas if I "occasionally feel terribly alone and isolated" in the course of a week that might be two occasions where for 15 minutes I suddenly think "God, what am I doing?"... which could be quite different to there {pre CORE} where it could have been an ongoing thing. It's only one point away...*

7.4.2.1.3 CORE: A 'technical' thing which needs interpretation

The CORE-OM is quite a 'technical' thing. For participants, the meaning of the CORE-OM scores and any change identified is not immediately obvious. Here there is potential for misunderstanding or misinterpretation until it is explained and interpreted. Using a results graph helped and provided a familiar 'technical representation' for people.

(001-2) *So I'm functioning worse? [No, that's an improvement, it's how they rate it, the lower the score the better, so on that level, there's an improvement on all this...]*

(021-3) *What does that {CORE score} tell me? I don't know really, until you tell me and show me what it means... there was no sense of this {change} at all, you filled those {items} in and some of them I had to think a bit about or wasn't sure about, should it be that box or that box, but I don't know what it means... [so the graph is a way of interpreting that] yes, ah huh.*

7.4.2.1.4 CORE: An ordeal - like asking you to run a marathon with a broken leg

Being presented with the CORE-OM can initially feel like quite an ordeal, especially when in emotional or cognitive pain. The questionnaire requires a person's cognitive and rational engagement when it is this very ability to engage cognitively and rationally which may be impaired. As one participant put it, it was like asking you to "do a marathon when your leg is broken".

(008-2) That's like work. Maybe it's me being lazy but it's like work for somebody who's thinking is the problem. It's not as if they've got a sore leg and I've broke my leg, excuse me... But that takes thinking. That's taking that which is ill.. it's like asking me to do a marathon with a broken leg. You know what I mean. Because that's what you're dealing with. You're dealing with the mind... and it's the mind that's ill. So that's an ordeal, or it can be for somebody that's got anxiety.

(038-2) I just feel my thought process just now has changed. My understanding... I just feel as if... it's harder for me to understand... I've actually had to go for help... see some of these documents, government forms for housing problems and all that. I've had to actually go and get help to get it filled out, because I've just thought to myself, I can't cope... I've lost a wee bit... my thinking has changed...

7.4.2.2 The LSM as a creative/‘irrational’ task

In comparison, the LSM typically engages people in a more creative and ‘irrational’ process of relating their problems and issues. A ‘blank canvas’ is confronted upon which a person ‘projects’ aspects of their life. Here the markings on the paper have much more significance than their conceptual representation as words or pictograms. From a participant’s perspective, there was a sense of using a different part of the brain, that it required being more artistic and expressive. Rather than a purely rational process, this gave space for less ‘conscious’ aspects to be seen. Here the colour, placement and overall structure of what was put down on paper had significance. This was associated with a sense of the LSM ‘hitting you in the face’, that it is quite evocative and spoke directly to people without needing to be analysed or interpreted. This allowed change to be ‘seen’ very immediately, like seeing a film of your life in ‘fast forward’. Though the creative nature of the LSM was experienced as being very powerful, it was also problematic in terms of people having difficulty being expressive. There was a sense of people potentially feeling ‘under the spotlight’, of being pressured to express themselves in an unfamiliar way. For some, it was also quite childlike, like being back at school. Depending on people’s background, this could be quite a negative association, whereas for others, it was more playful.

7.4.2.2.1 LSM: Uses a different part of the brain

Participants reported a sense of using a ‘different part of the brain’ to complete the LSM versus the CORE-OM. The visual nature of the LSM was seen as being able to express things that words alone could not. Here there was also a sense of allowing less ‘conscious’ parts of the mind to be ‘seen’, that things ‘came out’ in people’s drawings that they were not fully aware of previously.

(014-2) That {CORE} you're just filling in a form. That {LSM} I use a different part of my brain more readily - even though I'm not an artist... I can make this more mine whereas that {CORE} you've probably got others that are very similar... But you wouldn't, definitely that {LSM}.

(033-1) I think the colours worked just as well, I mightn't have got that across so well with words... I think words would have distracted me because the words... what words can you use for, or to have the weight of the visual...

7.4.2.2.2 LSM: Imagery 'speaks' directly to you – hits you in the face

Participants clearly saw the significance of the imagery of their LSM. Both the colours and the layout spoke directly to people, and ‘hit them in the face’, rather than needing to be interpreted or calculated as with the CORE-OM. There is also a sense here of ‘seeing’ the significance of the whole image, that it takes on a different meaning and significance from the separate parts of it.

(008-2) *That was turmoil. That was my mental state... Even not even reading it and just looking at that... It's just confusion. There's no pattern there that says I'm okay. It's so different with the lines and the design and the colours. It's just muddle. Absolute muddle. Dreadful.*

(021-2) *I think the pictorial ones {LSM} because they are so stark, and they hit you in the face in a oner, rather than oh that's 1.5 and that's 0.5 or whatever. But again, certain elements there {LSM}, it's very... you get some very clear instances within that. But you have to kind of look a wee bit harder at that {CORE}, whereas that {LSM} just hits you looking at those, those two bits. Even doing upwards and crosswards, there's a very significant difference.*

7.4.2.2.3 LSM: Like a film of your life

Participants reported that the visual nature of the LSM allowed them to directly *see* change for themselves. There is a sense here that differences are immediately apparent, that people are able to recall how they were when they first did their LSM, then 'fast forward' the film of their life to later on to see what has changed.

(003-2) *Yeah, I think definitely a visual thing is probably good... seeing it all there - it's like somebody saying to you at the beginning you were like this but now you're saying you're like this - it doesn't really put it into context, whereas if you see it visually it makes it more believable, more real. The fact that it's me that sat and wrote this - it wasn't you that done it - it was me. It makes it easier to understand.*

(014-2) *It's quite amazing because the only other time you would see that {LSM} is if you made a film of your life, and even then it would have to be artistic, or through dream sequence when you're working through things and that's not a true reflection. So it's actually quite good... I would say that this would be quite a good method put into counselling because I could see it being a useful tool - both just to do this for a one off and also the two... it would be a good tool to be part of a sequence.*

7.4.2.2.4 LSM: Difficulty being expressive

For some participants, it was difficult to actually express themselves. This was particularly problematic when someone is not used to more visual/drawing style of expressing themselves, or when the 'issue' they are coming for counselling for is around self expression. Here there is a sense of the 'spot light' being on someone who does not like to be 'seen'.

(002-3) *That {LSM} was more scary - I've never been asked to do anything like that in my life before. I didn't even know what a life map meant or anything.*

(017-2) *I think it's a psychological thing, putting expression down, not knowing what to say, no words come out, can't really get it out... [part of the reason you came was the anxiety of expressing yourself, and here I am asking you to do that first off...] yeah, the spot light is on me.*

7.4.2.2.5 LSM: Quite child like

The experience of drawing the LSM felt quite child like, that it had a sense of taking people back to being at school. For some this had negative connotations, that it made them feel a 'right idiot'. For others, there was a more playful aspect to this.

(006-2) *It's a bit strange {laughs} probably could have done better ones, it is quite child like, but that's just me, and I like that part of me now...*

(017-2) *The first time I came and wrote it I felt, when I walked out, I felt like a right idiot, just writing stuff like as if you're at school, and I was a little kid... it just felt odd, because I was so anxious at the time I was writing it - "what do I write here, I don't know what to write"...*

7.4.3 Linear/Static versus Nonlinear /Dynamic processes

This dimension represents the difference between a method being relatively linear and static in structure, to one which is nonlinear and dynamic. The process of completing the CORE-OM is typically linear, and does not significantly change from person to person, or at different times. In comparison, the process of completing the LSM is very dynamic and nonlinear, changing each time a person does it.

The CORE-OM as a linear/static process	The LSM as a nonlinear/dynamic process
Consistent and 'solid'	Making connections - putting things together
Regimented and inflexible	A natural flow - let your hand do the walking
Nothing new here	Allows subtle changes to be seen
Misses subtle shifts 'between the lines'	Quite broad and unboundaried
Items interpreted differently from pre to post	

Table 7-17 Summary of codes for linear/static versus nonlinear/dynamic process

7.4.3.1 The CORE-OM as a linear/static process

The process of completing the CORE-OM is essentially linear in nature. People start at the top and work their way through, item by item. Each item has a discrete set of 'boxes' that can be used to respond which are static in nature, and can not be altered. Here there is a sense of rigidity, a static container into which a person must fit themselves. From a participant's perspective, this can be experienced as potentially enabling and reassuring. The 'rigid' nature of the measure seems to offer a sense of consistency and solidness. However, this can also be experienced as regimented and inflexible. The static nature of the CORE-OM was also experienced as not providing an opportunity for discovery, that there was "nothing new here". In terms of measuring change, participants reported that subtle shifts and differences were missed, that there were changes 'between the lines' of the questionnaire which could not be represented due to its discrete, static nature. Participants also reported that they interpreted the meaning of some questionnaire items differently at the end of therapy than before therapy, such that the 'score' of an item meant something completely different than it did previously. There is a sense here that participants were not necessarily responding in a linear and static basis assumed by the scoring procedure, such that the resultant 'numbers' would be an inaccurate representation of change.

7.4.3.1.1 CORE: Consistent and 'solid'

The static nature of the CORE-OM gives a sense of consistency and solidity. Knowing that the questions had not changed, but that their answers had, gave participants a 'solid' sense that things were different. This 'solidness' was also evident in terms of not avoiding difficult issues, that the questions were direct and to the point, giving participants a sense of permission that it was okay to acknowledge things that could otherwise be difficult to admit to.

(019-3) *There's something solid about that {CORE}. It's consistent, it's the same scale every single time, so it's like, to compare one with the other it's the best way to do it. So the questions that I filled in, it doesn't really matter its just that it was the same each time.*

(043-2) *I think it identifies a lot of how I feel. I think it's very direct in the questions and doesn't beat around the bush, they are very straight to the point.*

7.4.3.1.2 CORE: Regimented and inflexible

Completing the CORE-OM, people are presented with a fixed set of questions and a limited set of answers. This can be experienced as being quite regimented and inflexible, like being forced to fit into some sort of box.

(008-2) *You're restricted, you're really restricted here {CORE} right... With that {CORE} you've not got choice, you're got to study and go that's 1,2,3,4. [Like being forced into...] Yes. Regimented. [Regimented. To fit yourself into something which...] Into some box...*

(014-2) *Oh no, there is definitely not spontaneity there... there isn't a lot of room for spontaneity even though I was trying to think... because I had the inclination to just go oh tick, tick, tick... [Not a lot of space for discovering anything with that {CORE}, would that be...] I would say that would be pretty true, but that could just be me...*

7.4.3.1.3 CORE: Nothing new here

There can be a sense of 'nothing new here', that in completing the CORE-OM a person is not required to 'stretch' themselves. One participant related this as "your thinking has been done for you", that you just need to respond to what is already there on paper rather than 'discover' things for yourself. There is both a positive and negative quality to this - that it is not overly taxing to complete, but that it also does not allow exploration, an opening of new avenues etc.

(001-3) *Your thinking is done for you - did you do this or didn't you do this more or less... but your thinking has been done for you. [The prompts are there - it's just responding to what is already there?] Yeah. Maybe a bit like a questionnaire in a magazine...*

(014-2) *I've lived with myself for 43 years so I kind of... [there's nothing new there...] well, not in the way where as this {LSM} gave avenues, whereas this {CORE} here I didn't feel gave... you were ascertaining a mood here {CORE} which is slightly different from here {LSM}. This {LSM} has a broader canvas if you like. There is more avenues to explore, the colour, the... like you're using the tools, you're painting a picture, whereas that is... There's not any questions that would shock me...*

7.4.3.1.4 CORE: Misses subtle shifts 'between the lines'

The discrete nature of the CORE-OM seemed to miss subtle shifts 'between the lines' of the questionnaire. Participants reported seeing distinct differences between their questionnaires even though the actual responses to items may have been very similar.

(003-2) *Not really much has changed... but when I think about the times... this one {pre CORE} was all day everyday, whereas this one {post CORE} is more at night. When I look at the two I see just how similar they are, but they are very different... I do still feel the same way but it doesn't affect me the same way. That's what the difference is... I can still feel this way and live a normal life.*

(014-2) *I still feel they may have worked out the same but between the lines there are subtle difference... at least I feel myself they are subtle differences.*

7.4.3.1.5 CORE: Items interpreted differently from pre to post

A number of participants scored items on the CORE-OM differently at the post-therapy stage than at the pre-therapy stage. Here the process of psychological change potentially shifts the reference point that a person uses to respond to the questionnaire, or changes the meaning of a question. As

such, an actual positive (or negative) change for the participant may be misinterpreted by the predefined linear scoring scheme as a negative (or positive) change.

(006-2) [*"I have felt criticised by other people" is sort of middle of the road {sometimes} - does that feel like that's a problem to you?*] No, criticism used to really annoy me... sometimes the people in my life are quite critical, some of them are just quite opinionated, and I've always been given "you should do this" and "you should do that"... my ex-boyfriend was very critical... and my mother is very critical because she is bi-polar and so she has always criticised me since I was wee... [It's interesting because on the one beforehand {pre CORE}, "I have felt criticised by other people" is actually less, it's 'only occasionally'] I don't think I realised it as much... I didn't really realise I was being criticised. I just thought I was doing a lot of things wrong...

(032-3) [*"I have thought I am to blame for my problems and difficulties", you've ticked 'often'*] I think, if you look back at these ones, the two previous ones I've said 'sometimes', and I understand that the reason I'm saying more often is because I'm more aware, I'm just so much more aware now that it's my own thoughts and beliefs that's causing me to behave the way I have, and that's what I'm continuing to work on.

7.4.3.2 The LSM as a nonlinear/dynamic process

In comparison, the LSM is a much more dynamic, nonlinear process. People can start anywhere on a 'blank canvas', with things emerging and evolving as the process goes on. A person may start drawing one thing which may then remind them of something else which they will start to draw, then later return to the original image. Things may have multiple meanings, or change meaning as the process unfolds. Here there is a sense of a 'space' which is shaped and manipulated by the person to fit them, rather than the person having to fit themselves to a preformatted space. From a participant's perspective, there is a sense of new connections being made, of new awareness unfolding through the actual process of constructing the LSM. This is experienced as a natural, flowing process, of "letting your hand do the walking" as one participant put it, rather than being a controlled or predictable undertaking. In terms of looking at change, the uniqueness of every LSM means that there will always be differences to be seen. Even when a person may previously not have thought anything was different in their life, upon seeing their LSMs they can identify subtle but significant changes. Rather than being linear in nature, there can be a multiplicity of meaning around the differences, allowing a person to see things from different angles. Though this process is typically quite enabling, there is also potential for it to feel quite broad and unboundaried. The nonlinear and dynamic nature of the process means there is no predefined end point, such that a person could potentially go on and on.

7.4.3.2.1 LSM: Making connections - putting things together

Doing the LSM allows people to make connections - people can put things together as they draw things that usually are not so easily recognised. Here there is a sense of exploring new avenues, of seeing new links emerging as the process unfolds. Additionally, in terms of looking at change, people can see *why* things have changed, they can make connections between the LSMs and see *how* things have changed over time.

(014-3) *It's also a good way of seeing things laid out, whereas if I just sat here you probably wouldn't see things like that... maybe talk about two out of three things or something like that, so you wouldn't get... Like you put something down and you say 'I could always put this in' and what have you.*

(019-3) *The diagrams {LSM} are much more personal. It can get me into a head space where I can remember - oh yeah, that was what I was going through then. From that I can make a lot more complicated links.*

7.4.3.2.2 *LSM: A natural flow - let your hand do the walking*

Drawing the LSM is a ‘flowing’ experience, like “letting your hand do the walking”. There is a sense here of being more ‘natural’ and ‘organic’ rather than forced or controlled, a fluid process that takes a person to places that they could not necessarily predict.

(008-2) *That's {LSM} self expression so, that's letting your hand do the walking and the drawing... That's flowing. I mean that's your anger. And you're writing down things and... That's more natural... You're going with it. You're going with the flow of how you're feeling...*

(014-2) *It's quite good because it's like trying to draw with my left hand... it will be more natural rather than sort of fully in control - it will be something that you might not have seen at first - it comes quite naturally from further down... it's come out somewhere.*

7.4.3.2.3 *LSM: Allows subtle changes to be seen*

Each LSM is so unique and different that it allows subtle differences and shifts to be seen and identified. This is particularly significant when the person previously thought that nothing had changed. Here the LSM allows a person to notice subtle differences which were previously overlooked.

(003-2) *I was thinking about it last night and this morning... Nothing has really changed... but actually, it probably has... it's probably quite a lot that's changed... quite small changes but important... You maybe need something to show you, something to look at to say that this is what you were like at the beginning and this is what you were like at the end. Although looking at the questionnaires it looks as if nothing has changed, but looking at the maps, well yes it has, and I hadn't realised.*

(037-3) *Do you feel you've moved again from this point?] Yeah, possibly, possibly a wee bit. Maybe not upwards, if you understand what I'm saying... [it's gone sideways...] Yeah, a slightly different view of things.*

7.4.3.2.4 *LSM: Quite broad and unboundaried*

Drawing the LSM can feel quite broad and abstract. There is a sense here that a person could get ‘lost’ a bit, that the open nature of the process does not provide a boundary for people, that there is potential for someone to be “up in the clouds” or to “scribble and scribble away”.

(021-2) *I felt it was quite... it was terribly broad in a ways... I found initially all right, but then I didn't know... it didn't feel like I needed to scribble and scribble away at it, that's fine, quite contained.*

(032-3) *I could probably think of things the first and the second time I did this {LSM}, and probably even that one as well, I probably could have sat for longer just going on and on and on about lots of different things, thinking "oh I wish I had thought of that"...*

7.4.4 *Advantages and disadvantages of the CORE-OM and LSM*

In addition to forming the dimensions discussed above, the identified themes can be grouped in terms of the advantages and disadvantages of each method. The following table summarises the themes above as either an advantage to or a disadvantage to the participant. Where a theme has both advantages and disadvantages, it has been grouped into the category which generally appears more prevalent for participants.

CORE-OM		LSM	
Advantage	Disadvantage	Advantage	Disadvantage
External versus Internal reference schema			
Checklist of problems/changes	Too general – not relevant to me	Puts you more in touch with your feelings	Hard to 'put it onto paper'
Realising problems are quite common	Items scored differently from their intention	I'm in control – allowing things to emerge	More to it than meets the eye
Makes you 'check in' with yourself	Covering up how bad things were	Makes things more tangible	
Objective confirmation – so I don't just feel it		Makes you 'break it all down'	
Comparison to 'average' person significant		Takes you back – like a photocopy of the brain	
Cognitive/Rational versus Creative/'Irrational' task			
Like doing multiple choice	Debating with yourself – difficulty fitting into a box	Uses a different part of the brain	Difficulty being expressive
	A 'technical' thing which needs interpretation	Imagery 'speaks' directly to you – hits you in the face	Quite child like
	An ordeal - Like asking you to run a marathon with a broken leg	Like a film of your life	
Linear/Static versus Nonlinear /Dynamic processes			
Consistent and 'solid'	Regimented and inflexible	Making connections - putting things together	Quite broad and unboundaried
	Nothing new here	A natural flow - let your hand do the walking	
	Misses subtle shifts 'between the lines'	Allows subtle changes to be seen	
	Items interpreted differently from pre to post		

Table 7-18 Advantages and disadvantages of CORE-OM and LSM

This table clearly shows significantly more advantages for the LSM (11) than for the CORE-OM (7), and significantly more disadvantages for the CORE-OM (10) than for the LSM (5). However, it must also be remembered that the themes within the table are not representative of every participant's experience, and do not provide an indicator of frequency or 'weight'. Hence it is best to consider this table as a representation of the *possible* advantages and the *possible* disadvantages of each method from the participant's perspective.

7.4.5 Effectiveness

In order to get a more direct assessment of the relative value of each approach from the client's perspective, participants were asked to relate which method they felt reflected their change from therapy more effectively. Six participants (35%) clearly found the CORE-OM to be a more effective indicator of change than the LSM. In comparison, four participants (24%) found the LSM more effective than the CORE-OM. Significantly, however, six participants (35%) felt that they could not really prioritise one over the other, and that a combination of both the CORE-OM and LSM gave the best indicator of change. One participant did not respond. The following gives a flavour of the types of the responses for each of these categories.

7.4.5.1 CORE-OM more effective than LSM (35%)

The CORE-OM gave participants a quantifiable indicator of change which they could easily relate to. Here there was a sense of the CORE-OM scores, and in particular the results graph, giving a clear and concise indicator of change.

(032-2) Because I've done a lot of graph work in my work, I can look at that {CORE} and see that that is a huge change, so for me, the graph is something that I look at and say "wow, look at that"... If I was given the choice, knowing now, if you were only able to do one thing to get some sort of before and after, I would go with the questionnaire and graph.

(040-2) I think the questionnaire was more useful, and to see the graph. Whereas that {LSM} I could have drawn a totally different picture... The graph does, I can see it there. [you can really see the change there] yes. And I wouldn't say I was a very technical person but I can see that.

7.4.5.2 LSM more effective than CORE-OM (24%)

For other participants, the LSM offered a more personally meaningful representation of change, one which was more specific and unique to the individual. Here there is a sense of the LSM providing a very idiosyncratic indicator of change.

(003-2) Although looking at the questionnaires it looks as if nothing has changed, but looking at the maps, well yes it has, and I hadn't realised... If you had just done this questionnaire with me and said to me at the end right, well, you can see for yourself that nothing has changed. But looking at it like this {LSM} it is definitely, definitely very very helpful, just to be able to say, it has changed.

(006-2) [Which has been a more significant measure of the change?] The life maps, because colour is quite important to me. I wear all different colours of cloths, so it's a way of expressing myself... the red is... it's quite kind of... it just shows how hurt I was.

7.4.5.3 LSM and CORE-OM equally effective and required (35%)

Significantly, a large proportion of participants felt that both the LSM and the CORE-OM were necessary to get a real picture of the changes. Here there is a sense of one feeding into the other, that only by using both methods could a true picture of change be formed. Because the methods are so different, they each provide "different parts of a puzzle". The CORE-OM can give very clear and specific indicators of change, whereas the LSM can help explain and contextualise the changes.

(019-3) I feel more informed by the maps, in that they are richer. The scores is a very simple, a clear jolt of yeah, great, things have improved. But if I had that {CORE} without seeing that {LSM} I wouldn't really understand why things had improved necessarily. So in terms of the overall process of continuing to improve, I don't know. They do feed into each other a bit... the changes on the scores on the CORE, I wouldn't understand why the changes had happened, whereas here {LSM} I do. Likewise looking at these diagrams, I wouldn't have been able to say for sure that things had improved. They might have just got worse, or stayed the same... [it's very hard to put values on the maps] absolutely, yeah... totally, that's it. They are interpretive, subjective, but were really useful so they do work quite well together.

(043-2) I feel as if I choose one I'm dismissing the other, and I don't think that it would be right to dismiss either. Because they are so different it almost feels that you would be dismissing one or the other, and I just couldn't do that because I find it's all necessary and relevant. Because there is so much of this {CORE} relevant to what I've done here {LSM}, that I don't dismiss things that I've done there. Its all different parts of a puzzle. I would find it hard to just stick to one.

7.4.6 Ease of use

In addition to being asked how effective each method was, participants where asked explicitly about which method they found easier to use. The significant majority (70%) identified the CORE-OM as being easier to do, while only 2 (12%) indicated that the LSM was easier to do with 3 (18%) expressing no preference. The following quotes give a flavour of the types of the responses given by participants.

7.4.6.1 CORE-OM easier than the LSM (70%)

(001-3) I think the questionnaire makes it a little bit easier for you. It's a multiple choice question type of thing. It's easier to tick something than put your thoughts down on paper. It was easier to fill that {CORE} in.

(037-1) I found it a wee bit more difficult to put things down on paper there {LSM}. But once I kind of got going, things started to come to fruition. Outwith that, I didn't have a problem with the other side of things, the questionnaire wasn't a problem to me at all.

7.4.6.2 LSM easier than the CORE-OM (12%)

(008-2) That's {LSM} easier because that's self expression. You're restricted, you're really restricted here {CORE} right. That's {LSM} self expression so, that's letting your hand do the walking and the drawing. With that {CORE} you've not got choice, you're got to study and go that's 1,2,3,4.

(020-2) [Which did you find easier to do] I liked the drawing {LSM}... I like that. I found it quite therapeutic to draw and paint... I love it. I don't feel I'm very good at expressing myself writing on paper, but I love to paint and draw. [When you say writing, does that include the questionnaire] ah huh, I think so.

7.4.7 Thematic analysis summary

This thematic analysis of participants' experiences of using the Life Space Maps and CORE-OM reveals a number of key results in terms of the aims of the research project.

- Participants' experiences of using the CORE-OM and LSM can be seen to vary along the dimensions "External versus Internal reference schema", "Cognitive/Rational versus Creative/'Irrational' task", and "Linear/Static versus Nonlinear /Dynamic processes"
- Participants identified significantly more advantages and significantly fewer disadvantages of using the LSM compared to the CORE-OM. However, these findings do not take into account the relative magnitude of the different advantages and disadvantages.
- Potential advantages of the LSM include: putting you in touch with your feelings; being in control; making things more tangible; allows you to break it all down; can put things together; uses a different part of the brain; imagery speaks directly to you; like a film of your life; a natural flow; and allows subtle changes to be seen.
- Potential disadvantages of the LSM include: being hard to put onto paper; difficulty being expressive; hidden meanings (more to it than meets the eye); quite childlike; and quite broad and unboundaried.
- Potential advantages of the CORE-OM include: providing a checklist of problems and changes; realising problems are quite common; makes you to 'check in' with yourself; objective confirmation; comparison to 'average' person; consistent and 'solid'; and easy to do (like doing multiple choice).
- Potential disadvantages of the CORE-OM include: being too general; open to misinterpretation (items scored differently from their intention, items interpreted differently from pre to post); open to manipulation (covering up how bad things were); difficulty with fitting into a box; needs interpretation; can be an ordeal; too regimented and inflexible; nothing new is learnt, and misses subtle shifts 'between the lines'.
- 35% of participants reported that the CORE-OM was clearly a more effective indicator of change, while only 24% reported that the LSM was a more effective indicator. However, 35% reported that a combination of both gave the best indicator of change.
- 70% of participants reported that the CORE-OM was easier to use than the LSM, while only 12% reported that the LSM was easier to do than the CORE-OM.

7.5 Experience of being part of the research

In addition to exploring the participants’ experiences of using the CORE-OM and LSM to evaluate outcome, the study was also designed to allow participants to reflect on their overall experience of being part of the research. The aim here was to explore how participants experienced being part of a study which adopted a collaborative approach to investigating outcomes. The most significant theme to emerge here was the value that participants placed in being given an opportunity to ‘see’ change for themselves. Additionally, some participants found the experience to be therapeutic in its own right. However, a couple of participants expressed concern that the experience might bring things back up for them. Finally, a couple of participants referred directly to the importance of a facilitative, non-judgemental relationship with the researcher as being key to allowing them to express themselves as openly as they did.

The following sections use a scheme for describing the ‘weighting’ of themes using ‘plain English’ terms to describe the frequency of occurrence (see Appendix H: Proposed Scoring Scheme for Qualitative Thematic Analysis). Direct quotes from participants have been included to give a fuller flavour of each of the themes.

7.5.1 Allowed me to 'see' change for myself

Most (10 out of 17) participants related that being part of the research had allowed them to reflect on how far they had come from the beginning. The research interviews gave people a chance to see the ‘process’ of counselling unfold for themselves by providing ‘markers’ or points of reference that they could remember and reflect on. It also allowed a reflection on how things had continued to change after the counselling had finished. For one participant, there was also a realisation of how quickly life can change, and that it could just as quickly change back again.

<i>(001-3) Taking it as a whole, I will gain a help out of it, because I can look back and I didn't just come along and nothing had improved. And because I was involved with the research - if you hadn't been around I would have just gone to see {the counsellor} and been off, and I wouldn't have had the proof. I would have only had my own feelings, whereas this sort of stresses the fact that there's been an improvement in my life... {more concrete?} yeah, concrete is a good word.</i>
<i>(017-2) Doing the research has probably made me more aware of how I'm feeling, and it's good to feel that I've got a slight better feeling about myself and a slight mood change... even if it's just paper work, I still see a change myself, for me, not just for you...</i>
<i>(019-3) It is certainly a much richer experience than last time I had a counsellor. In comparison this time where there has been this at the start and the end of the process, I've become much more conscious of it as a process, rather than just "I'm going to go to speak to someone" if that makes sense. [It has brought an awareness that there is a process going on there] yeah, totally, and there is clear change both there {post-therapy} and there {follow-up}</i>
<i>(021-3) I think it's quite positive to do that because, six months ago {post-therapy interview}, to have had a look at things then and a kind of reflection, and then six months on to reflect. I've only done that because it's part of the research. I wouldn't have had that opportunity. It feels very affirming. I don't know if I hadn't done that how much I would have been able to say I have come a long way and reflect on the progress I've made.</i>

(032-2) I think it's gave me a huge insight into just how your life can change, and change so dramatically and so quickly. Because it hasn't been that long that I've gone through this change... It makes me want to be more careful, to look out for any changes that could look like depression is taking in sort of thing. There's a huge change where your life can go from that to that, and nothing's saying it couldn't go back to that again. I think it's me that's in charge of that, to see the signs and putting things in place...

7.5.2 Therapeutic

Some (6 out of 17) participants reported that their experience of the research interviews had been 'therapeutic' in its own right, that actually talking to someone had a direct therapeutic effect. This occurred during all stage of the study including the pre-therapy interview, the post-therapy interview and the follow-up interview. It would seem that the pre-therapy interview has the potential to help people explore their issues before the counselling begins, while the post-therapy interview can help to process some of what went on in counselling. The follow-up interview seems to offer people a chance to talk about things in a way which they may not have had an opportunity to do since their counselling finished.

(008-1) This is quite good actually. I find this quite good really because I've seen programmes on the TV and they say getting it down on paper helps to empty anger or understand your anger – understand how you're feeling. Maybe I should be doing this more at home instead of sitting there on your own being bored get a bit of paper and go aaaah. Sometimes you just want to scream. You know and maybe that's just quite therapeutic stuff.

(014-2) Maybe I should be paying you for the counselling because I haven't actually spoken about what happened with my counselling until now. That's possibly been a form of release as well. Even though I've been straining, had problems expressing myself, its just because I've put up a wee bit of a wall, and maybe its been good to take the top layer of moss of the wall. Maybe you didn't intend for that, but it's been quite good. I found it quite good.

(017-1) It feels good to actually get something off your chest as well, as if you're talking to a counsellor... it's good to actually express it... to actually look back now and say "at least you wrote something down", you maybe feel better for it... it's helped in getting it out... been wanting to express it. All it takes is for somebody to talk to you the right way to get it out...

(037-3) It gives me a chance to speak to someone that knows exactly the problems that I'm enduring. I'm not saying that you can resolve them or anything but it certainly lets me put my point across, and it shows you generally how things have progressed or worsened. I find that comforting from that point of view.

7.5.3 Worried that it might bringing things back up

A couple (2 out of 17) of participants expressed concern about coming for the post-therapy interview in that it might bring things back up for them. In particular, one participant who had stopped counselling prematurely was concerned about how they were going to cope afterwards.

(033-2) I just wondered how I would deal with it all, coming back to it all. Because I just wondered if it would bring back the feelings I was having at the time, and I was a bit nervous how I would be with that.

(043-2) Coming back is very strange because I didn't see myself as coming back here again, because I put a lot of things to the back of my mind, out of choice a lot of it - I didn't want to think about a lot of things. At the same time, if it was going to be too much for me I wouldn't have come. I can face up to things. I do have a worry about how I'm going to be now, because I've almost had a taste of what this is all about again, and I'm not going to have it again... a bit worrying about how I'm going to cope again...

7.5.4 Importance of the research relationship

A couple (2 out of 17) of participants referred directly to the importance of a facilitative, non judgemental research relationship in order for them to feel safe enough to express themselves.

(014-2) Your relaxed, friendly but professional manner has enabled me to feel enough at ease that I could express here and I could fill you in on my stick drawings... Although I didn't mean to 'off load' on you, it was almost accidental that I did that, that I felt relaxed enough to speak about it and said as much as I could... I would think you wouldn't get the full picture, you wouldn't get as much if you didn't have that.

(033-1) It's been difficult but it's been good. Just thinking about the questionnaire and doing that with the colours, it's good for me to see that. At least I have some idea that I don't feel, that it's okay to do that, that no one is going to judge me by that or ridicule me for it, so that's been quite good.

7.5.5 Summary of participants' experience of the research

This analysis of participants' experiences of being part of the research project reveals a number of key results in terms of the aims of the research project:

- Many participants highly valued the opportunity to review and reflect on the changes that had occurred for them, both over the duration of therapy and after therapy has finished.
- Some participants experienced the research interviews as being therapeutic in their own right in terms of offering a chance to explore issues and problems before counselling began, to process some of what went on in counselling at post-therapy, and to revisit things at follow-up.
- A small number of participants worried about 'bringing things back up' in the research interviews, in particular when therapy finished prematurely.
- A few participants noted the importance of a facilitative and non-judgemental research relationship in terms of feeling safe enough to express themselves.

8 DISCUSSION

This final chapter brings together the various themes and issues explored in previous sections of the thesis, and discusses what the study offers in terms of being an original contribution to the existing knowledge base. At its conception, the aim of the study was to explore, using collaborative methods of inquiry, the possibility that Life Space Mapping might represent an alternative to the CORE-OM for evaluating regular outcomes of therapy. However, through the process of conducting the research project, the study has become somewhat of a ‘heuristic journey’ with the unfolding of new learning which unearthed issues that had not been anticipated at the outset. This chapter therefore begins by revisiting the research questions that initially provided the framework for the study, as outlined in Section 4.1 above. In order to give a succinct overview of the conclusions of the study and the new knowledge developed through the thesis, a brief summary is given of the key findings in relation to each research question. This overview is followed by a discussion of the methodological strengths and weaknesses of the study to create a context in which the validity of these findings can be assessed. A more detailed discussion of the main issues addressed in the thesis follows, before concluding with some suggestions about the implications of the findings for practice, training, research and funding of counselling and psychotherapy.

8.1 Research questions revisited

This section brings together the key research findings from the results section in relation to each of the research questions introduced in Chapter 4.

8.1.1 What happens when we investigate the outcomes of counselling and psychotherapy using collaborative methods that incorporate the client’s frame of reference and self reflection on change?

The study indicates that when used in a collaborative manner, the Life Space Mapping method can evoke rich, in depth narratives about the kinds of problems, the causes of these problems, and resources a client can adopt to cope with problems in their life, and to relate these from their own frame of reference (see Section 7.1.2). Further, the LSM interview can allow clients to reflect on the changes and the attributions for these changes over the duration of therapy (see Section 7.1.4). Life Space Mapping has proved to be highly idiosyncratic in nature, with maps varying from very structured ‘node link’ styles and graphical drawings, to extremely wordy accounts and ‘letters to self’, to detailed pictograms combined with brief words, to highly abstract representations with no words at all (see Section 7.3 for examples of different styles of LSM). Further, the style of Life

Space Map that any one person uses may remain fairly static over time or may change significantly from map to map (see, for example, Figure 7-6 versus Figure 7-18). Though the LSM approach allows a highly individualised form of expression, this idiosyncratic nature means that it is difficult to interpret accurately without at least a brief contextualising narrative from the client (see, for example, Figure 7-14). As such, it would seem that the Life Space Map approach is particularly well suited to case study style research (see Section 7.1 for a detailed example of a case study utilising the LSM and Section 7.3 for examples of a number of caselets) rather than being ‘interpreted’ or analysed from an external perspective.

Whilst Life Space Mapping proved a viable and useful method for exploring idiosyncratic outcomes of therapy, it is apparent from the study that this approach has a number of limitations compared to when standardised outcome measures are used. In particular, the availability of normalised data for quantitative measures such as the CORE-OM can confirm that participants achieved an objectively recognisable (clinically significant) and statistically reliable level of change, rather than a purely subjective level of change (see, for example, Section 7.2.2). Additionally, quantitative data analysis of CORE-OM scores allow the direct comparison of cases which is just not possible with the LSM. Further, such data allows the results of a study to be directly compared to other studies (see Section 7.2.4). The analysis of quantitative data also allows interesting cases to be easily and routinely identified and flagged for closer examination without requiring a detailed investigation of each individual case (see, for example, Table 7-9). Further, the use of quantitative data offers a method for checking on systematic problems with a study such as high drop out rates for more distressed participants (see, for example, Table 7-11). As such, it would seem that the Life Space Map approach is not best suited to being used in isolation for routine clinical monitoring, or other situations where direct comparisons are required either between participants or across different studies.

The study also reveals that from a client’s perspective, a significant number of people may value the opportunity to review and reflect on the changes that have occurred for them over the duration of therapy, as well as ongoing changes after therapy (see Section 7.5.1). Some clients may also experience a collaborative approach to research as being therapeutic in its own right by offering a chance to explore issues and problems before counselling begins, or to process some of what went on in counselling at post-therapy, or to revisit things at follow-up (see Section 7.5.2). A small number of clients may have concerns about ‘bringing things back up’ in the research interviews, especially if therapy finishes prematurely for any reason (see Section 7.5.3). Here the presence of a facilitative and non-judgemental research relationship would seem significant in terms of allowing people to feel safe enough to express themselves to the extent that they are most comfortable with (see Section 7.5.4).

8.1.2 What different ‘view’ of outcome can this approach to assessing the outcomes of counselling and psychotherapy yield compared to using a conventional pre/post questionnaire design?

Life Space Maps can provide a highly evocative and personalised visual representation of change over the duration of therapy (see Section 7.3 for examples). Further, LSM interviews can provide rich, in depth narrative accounts which can be analysed to identify changes in the extensiveness and significance of problems, causes of problems, resources and coping strategies, perceived changes, and attributions of changes (see Section 7.1.7). This analysis is able to reveal subtle changes over the duration of therapy such as shifts in time perspectives of problems (see Table 7-1), a greater differentiation of the causes of problems (see Table 7-2), and changes in the use of coping resources over time (see Table 7-3). Of particular interest, the approach is also able to reveal the client’s own view of change (see Table 7-4) along with their view of what these changes are attributed to (see Table 7-5). This constructs a very different ‘view’ of outcome whereby change is contextualised within the person’s wider social world rather than along predefined dimensions as with the CORE-OM. Further, therapy is seen as just one of many other resources that a person can draw upon.

In comparison, the analysis of the CORE-OM data collected using the conventional pre/post questionnaire design provides a succinct overview of the patterns of change for all participants over the duration of the study (see Table 7-9) as well as giving clear indicators of change in comparison to normalised data (see Table 7-12). Such an overview is not possible with the Life Space Map approach as there is no simple way to aggregate or compare changes in LSMs for groups of people. Similarly, the CORE-OM graph provides an instant and definitive indicator of improvement or deterioration which is not immediately obvious when comparing LSMs (see, for example, Figure 7-13 versus Figure 7-14). Interestingly however, there would seem to be some potential for comparing the analysis of client’s problem narratives generated from the LSM interviews with changes in the CORE-OM severity levels (see Table 7-1 versus Table 7-6).

When taken together, it would appear that these two different approaches provide a complementary ‘picture’ of outcome which is fuller than either one on its own. It is also readily apparent from the case study (see Section 7.1), the montage of Life Space Maps and CORE-OM graphs (see Section 7.3) and the thematic analysis of participant’s experiences of using the methods (see Section 7.4) that both approaches are best understood in combination with the client’s own narrative account.

8.1.3 How do clients feel about using a creative, visual method for evaluating the outcomes of counselling and psychotherapy compared to using a standardised quantitative questionnaire?

The study demonstrates that a creative, visual approach to investigating the outcomes of therapy can be highly welcomed by clients. Such an approach can allow a person to directly apply their thoughts onto paper and express themselves freely. In comparison, the CORE-OM can be experienced as being restrictive and potentially overwhelming, especially for someone who is struggling cognitively (see Section 7.1.9). Specifically, the study indicates that participants' experiences of using the CORE-OM and LSM vary along the dimensions of "External versus Internal reference schema" (see Section 7.4.1), "Cognitive/Rational versus Creative/'Irrational' task" (see Section 7.4.2), and "Linear/Static versus Nonlinear /Dynamic processes" (see Section 7.4.3)

Though 35% of participants reported that the CORE-OM was clearly a more effective indicator of change and only 24% reported that the LSM was a more effective indicator, 35% of participants reported that a combination of both gave the best indicator of the outcomes of their therapy (see Section 7.4.5). This indicates that around 60% of participants found the Life Space Map approach to be a valuable tool for evaluating the outcomes of their counselling, while 70% found the CORE-OM a valuable tool. Significantly, 70% of participants reported that the CORE-OM was easier to use than the LSM while only 12% reported that the LSM was easier to do than the CORE-OM (see Section 7.4.6). This indicates that while clients may find the LSM a valuable tool, it is generally experienced as more demanding and difficult to complete.

8.1.4 What benefits or drawbacks do people report from using the different methods for evaluating changes from therapy?

Participants identified significantly more advantages and significantly fewer disadvantages of using the LSM compared to the CORE-OM (see Table 7-18). Note however, that these findings do not take into account the relative magnitude of the different advantages and disadvantages. Potential advantages of the LSM include: putting you in touch with your feelings; being in control; making things more tangible; allows you to break it all down; can put things together; uses a different part of the brain; imagery speaks directly to you; like a film of your life; a natural flow; and allows subtle changes to be seen. Potential advantages of the CORE-OM include: providing a checklist of problems and changes; realising problems are quite common; makes you to 'check in' with yourself; objective confirmation; comparison to 'average' person; consistent and 'solid'; and easy to do (like doing multiple choice). (See Section 7.4 for details and examples).

Potential disadvantages of the LSM include: being hard to put onto paper; difficulty being expressive; hidden meanings (more to it than meets the eye); quite childlike; and quite broad and unboundaried. Potential disadvantages of the CORE-OM include: being too general; open to misinterpretation (items scored differently from their intention, items interpreted differently from pre to post); open to manipulation (covering up how bad things were); difficulty with fitting into a box; needs interpretation; can be an ordeal; too regimented and inflexible; nothing new is learnt, and misses subtle shifts ‘between the lines’. (See Section 7.4 for details and examples).

8.2 Methodological strengths and limitations of the study

The reliability and validity ‘quality’ criteria that informed the design and conduct of the study were introduced in Section 5.5. Below are detailed the strengths and limitations of the resulting study.

8.2.1 Limitations of the study

8.2.1.1 Recruitment and retention limitations

The findings of the study are based on a particular group of clients from a single counselling agency. Though this setting provided a good ‘naturalistic’ basis for exploring people’s ‘everyday’ counselling, it may be that the results obtained are relevant only to the specific clients who participated in the study, and that other clients with different presenting problems, different severity of problems or from different cultural backgrounds etc would have reported different experiences. There is also potential that only people interested in concept of ‘life space mapping’ agreed to participate in the research, hence biasing responses in favour of this method.

Further, the results of the study are only based on the 17 participants who completed both a pre-therapy and post-therapy interview. This represents only 40% of the 43 participants interviewed at pre-therapy. It could be argued that only clients who found the research interesting and beneficial continued to the post-therapy stage, and any who found it unhelpful or hindering dropped out of the study. There is also some indication that participants who were in the more severe levels of distress did not return for a post-therapy interview (see Table 7-11), again potentially biasing the findings.

The study was also reliant on counsellors at the agency proposing the research study to potential clients at the ‘intake’ assessment interview. There is potential that these counsellors influenced the recruitment process by only proposing the study to clients who presented with relatively mild problems, or in other ways seemed ‘appropriate’ for the research.

Additionally, the study was reliant on the counselling agency's existing case handling procedures. As such there was limited control over the gap between the pre-therapy interview and the start of counselling (see Section 6.4.1), meaning that the pre-therapy data was not always captured just prior to the participants' first session. Similarly, due to the agency's system of reporting closed cases, there was often a delay between a participants' final session and their post-therapy interview (see Section 6.4.2). As such, the collected data may not accurately reflect participants' immediate experiences of the end of therapy.

8.2.1.2 Researcher effect limitations

The findings of the study are based on the analysis and interpretation of only one researcher. There is potential here that the results may be influenced by the "allegiance bias" of this researcher in favour of the Life Space Map approach, and towards finding value in collaborative approaches to outcome research.

Further, the results of the study may be influenced by this researchers' specific interviewing style, or manner of engaging with participants. There is some evidence to suggest that at least some participants were directly influenced by this researcher's style of engaging (see Section 7.5.4).

It was also apparent that a number of participants viewed the researcher as aligned to and associated with the counselling service. There is potential here that some participants downplayed any problems with the research or their counselling, and over emphasised any benefits. This dynamic may have been amplified by the fact that all interviews were conducted within the counselling centre, rather than in a 'neutral' space.

8.2.1.3 Research design limitations

Although the analysis of the interviews was audited by the research supervisor, neither the case study analysis nor the thematic analysis was validated by the participants. The process of analysis took significantly longer than intended and was not completed until 3 years after the initial data was collected. After discussion with the research supervisor, it was decided to not validate the cases with the participants as this may have been an unwanted intrusion. However, this lack of member checking potentially reduces the credibility criteria (see Section 5.5) and should be taken into account when viewing the findings of the study.

Additionally, the design of the study did not allow participants who did not attend counselling to be interviewed. It may have been useful to augment the findings of the study with cases where no therapy was received, allowing a more diverse sample of participants. Similarly, the pre/post design of the study meant that no intermediate outcomes were available. The inclusion of mid therapy interviews and outcome monitoring may have provided a very different set of results.

Finally, the study did not ask participants to quantitatively rate the relative effectiveness or ease of use of the CORE-OM versus the LSM. This would have aided a more explicit comparison between the methods rather than relying solely on the researcher's interpretation of interview statements.

8.2.2 Strengths of the study

Despite the above limitations, the study has a number of methodological strengths that act to mitigate some of the above.

8.2.2.1 Recruitment and retention strengths

The results of the study are derived from a relatively substantial sample of participants from a range of educational and social backgrounds, with a variety of presenting problems and previous experiences of therapy and over a broad age range. In particular for a qualitative thematic analysis, this provided an unusually rich data set to draw upon.

Additionally, participants were recruited from members of the general public seeking help from an established volunteer counselling service. As such, it represents a 'real world' setting compared to studies conducted within University education programmes or research clinics. Further, there were no 'ulterior motives' or subtle incentives such as the provision of free therapy in exchange for participation.

Though the study had a large drop out rate, this may indicate that people felt sufficiently empowered to withdraw from the study without feeling obliged or coerced in any way. Further, participants who did attend reported that the research had been meaningful for them, and that they had gained from the experience.

8.2.2.2 Researcher effect strengths

Though the researcher may have initially been aligned to the Life Space Map approach, with the progression of the study this initial bias subsided as the value to participants of the CORE-OM was revealed. As such, the researcher became equally committed to each approach, seeing the advantages and limitations of each.

With regard to the potential influence of the researcher's specific style of interviewing, though this may have been noted by participants as being significant, it was in terms of being enabling and facilitating. Rather than being seen as a limitation, it can be seen as being consistent with a person centred approach to research (see Section 5.4).

Additional researcher effects can be seen in terms of the researchers' ongoing learning and experience which have shaped the analysis process throughout the study. Rather than being a

limitation of the study, this has allowed new angles to be brought to the analysis process and has resulted in a much richer engagement with the data than originally conceptualised.

8.2.2.3 Research design strengths

Though the design of the study did not include explicit validation with participants, this limitation is somewhat offset by the collaborative approach taken with collecting the research data.

Throughout the research interviews, the researcher routinely checked things out with participants, reflecting back what was heard and checking for subtle inaccuracies. In this way, there was a degree of ‘in situ’ member checking whereby participants were able to check and correct the researchers’ interpretation during the interview itself. Additionally, extensive samples of the participants’ own words have been provided throughout the results write up to allow the reader to judge the validity of the researcher’s interpretations.

With regard to the analysis of the data, the researcher undertook a number of diverse and systematic processes to compose the in depth case study analysis, the quantitative results, the montage of caselets, and the thematic analysis of participants’ experiences. This has provided the researcher an opportunity to ‘approach’ the data from multiple angles, and hence to engage at greater depth than any one method in isolation could have afforded. This analysis was also checked with an experienced research consultant.

8.3 Discussion of findings relating to the CORE-OM

This section highlights the key findings of the study in relation to the CORE-OM. Of particular interest, the current study was able to gather detailed accounts of the participants’ experiences of using the CORE-OM in a clinical setting. This data has been used to identify some key strengths and limitations of the CORE-OM from a participant perspective which are detailed below, along with a discussion of the implications of these findings for its use and interpretation.

8.3.1 Strengths, limitations and key features of the CORE-OM

8.3.1.1 Comparability to other practice based studies

The CORE-OM data analysis suggests that the quantitative results of the present study are fairly comparable to those obtained from a large scale study within the NHS (see Section 7.2.4). This indicates that the changes experienced by participants were on the whole not atypical. It also demonstrates the utility of quantitative measures such as the CORE-OM in allowing direct comparisons to existing data sets, both in terms of clinical normative data and other published studies.

8.3.1.2 Sensitivity to clinical change

In combination with the qualitative data, the results also tend to support the assertion of the instrument's designers that the CORE-OM is sensitive to clinical change (see 2.1.4). Data from the CORE-OM such as changes in severity levels of participants (see Table 7-9) was used to highlight potential cases of interest. When explored in more detail using the recorded interviews and Life Space Maps, this more qualitative assessment tended to largely concur with the patterns of change indicated by the CORE-OM data (see Section 7.3). Further, a more detailed analysis of the extensiveness and significance of one participant's problem narratives indicated a surprisingly good fit to changes in this participant's CORE-OM severity levels (see Section 7.1.8).

8.3.1.3 User friendly

Overall, the study supports the CORE-OM designers' contention that the measure is user friendly (see Section 2.1.4) with participants reporting that in general, it was quite easy to complete and similar to answering 'multiple choice' questions (see 7.4.2.1.1). Further, 70% of participants indicated that it was easier to complete than the LSM (see 7.4.6.1). However, participants also identified a number of key disadvantages of the measure which are discussed later in this section.

8.3.1.4 A checklist of commonly experienced problems and issues

The study also found that participants used the CORE-OM as a 'checklist' of commonly experienced problems and issues with which to compare themselves (see 7.4.1.1.1). The items on the CORE-OM gave participants an opportunity to 'check in' with themselves (see 7.4.1.1.3), to stop and consider whether a problem or concern was relevant or not. This was experienced as quite an affirming process as the person went down the 'checklist' and realised they did not score highly on some things, or had moved from their original score. The checklist also had the benefit of allowing participants to see that what they were experiencing was not 'abnormal' or 'weird', but instead relatively 'common' (see 7.4.1.1.2). Participants found this reassuring, and felt less isolated and different from everyone else.

8.3.1.5 The value of the CORE-OM as an objective measure for clients

The results of the study indicate that participants found the CORE-OM valuable as an 'objective' measure which allowed comparisons to the 'average' person. Participants seemed to associate easily with the concept of a clinical cut off, and found the comparison to an 'average' person useful (see 7.4.1.1.5). The CORE-OM scores also provided an 'objective confirmation' (see 7.4.1.1.4) which gave participants a sense of affirmation that it was not just their subjective perception that things had changed. An important characteristic here for participants was knowing that the CORE-OM was consistent over time (see 7.4.3.1.1), that the questions did not change so that any change indicated must mean that they had changed. Additionally, the graphs of the CORE-OM data were experienced as giving a clear and concise indicator of change which participants could relate to and found very effective for reflecting on the outcomes of their therapy (see 7.4.5.1).

8.3.1.6 Prevalence of response error

A key finding of the study was the discovery of how regularly items on the questionnaire are mis-scored in one way or another. For example, a number of participants misinterpreted items on the questionnaire such that they responded in an opposite way to that intended by the designers (see 7.4.1.1.7). This is a classic example of ‘response error’ as discussed in the Literature Review (see Section 2.2.5) where there is a lack of clear communication between the questionnaire designers and the respondent (Willis, 2005). Similarly, a number of participants acknowledged that how they had initially responded to some questionnaire items had not been entirely accurate, that they had ‘covered things up’ (see 7.4.1.1.8), demonstrating a further example of a ‘social desirability’ response error (Meier, 1994). Other participants reported that the questionnaire was an ordeal to complete (see 7.4.2.1.4), that having to engage cognitively and rationally in the task was problematic especially when the problems they were attending counselling for were affecting their ability to engage cognitively and rationally. The study also supports the assertion by Schwarz et al (1998) that the process of determining the quantitative meaning of potentially ambiguous response options on questionnaires is problematic. Participants reported having difficulty ‘fitting into a box’ (see 7.4.2.1.2), that the anchor points on the Likert scale were at times vague and ‘non-linear’.

What is startling about the findings from the study is not so much that response error exists, but rather how often it occurs. Of the 17 participants in the study, nearly 60% (10) reported one or more of the above response errors at some stage during the study. Whilst some of these errors may have had a relatively minor affect on the overall CORE-OM score, others such as the first example would have drastically overstated the participants’ psychological distress if it had not been checked out and corrected.

8.3.1.7 Response shift and gamma change

A further problem with the CORE-OM identified in the current study arises in terms of ‘response shift’ (Meier, 1994), where the way a person responds to questionnaire items changes from before to after therapy (see Section 2.2.6 of the Literature Review for a fuller discussion of this). For example, some participants reported that the CORE-OM seemed to miss subtle shifts ‘between the lines’ (see 7.4.3.1.4). Here a person’s CORE-OM scores remained static from pre to post-therapy, yet the participant reported that they ‘felt’ differently about how they had responded. Similarly, a number of participants reported that they had interpreted the meaning of some questionnaire items in a different way at post-therapy than they had a pre-therapy (see 7.4.3.1.5). This can also be seen as indicating that ‘gamma change’ (Golembiewski et al., 1976) had occurred in terms of a ‘quantum shift’ or redefinition of the psychological space of the participant such that the previous meaning of the ‘measurement’ has become irrelevant. These results support the concern that this issue is particularly problematic for therapy outcome research as the process of being in counselling has the potential to change the way a person conceptualises the meaning of questionnaire items (McLeod, 2001a).

8.3.1.8 Imbalance of power

There is also a suggestion in the results that participants experienced the subtle reinforcement of power differences discussed in the Literature Review (see Section 2.2.8) in terms of questionnaires being ‘administered to’ a ‘subject’ and then scored by an ‘expert’ who has the knowledge to interpret, and pronounce judgement on the meaning of the results (McLeod, 2001c). Here participants reported that the CORE-OM was quite a ‘technical’ thing which needed interpretation by the researcher before it could be properly understood (see 7.4.2.1.3).

8.3.1.9 Limitations as a collaborative tool

A final limitation of the CORE-OM that is highlighted by the current study is the potential for the questionnaire to not offer participants much of value in terms of being a collaborative tool. Some participants reported that the questionnaire was ‘too general’ and ‘not relevant’ to them (see 7.4.1.1.6), that it was not individual enough. Others indicated that the questionnaire was too ‘regimented’ and ‘inflexible’ (see 7.4.3.1.2), that it did not offer a lot of space for discovering anything new. This was also experienced as there being ‘nothing new here’ (see 7.4.3.1.3), that in completing the questionnaire, participants did not need to ‘stretch’ themselves in any way.

8.3.2 Implications for the use and interpretation of CORE-OM data

The above findings indicate that the CORE-OM generally offers a valuable tool for the evaluation of counselling and psychotherapy outcomes. The results offer a qualitative confirmation of the designer’s assertions that the instrument is clinically sensitive to change and relatively easy to complete. Further, the finding that participants utilised the measure as a checklist of common problems and issues should be of interest to practitioners in terms of indicating that the measure has clinical worth for clients themselves. Rather than being an imposition on clients, this finding suggests that the questionnaire may in fact be beneficial and potentially affirming.

Of even greater significance to clinical practice, however, is the finding that clients valued the opportunity to reflect on their change scores and their comparison to the clinical cut off points. This indicates that rather than being utilised purely as a data gathering tool, the CORE-OM could become a valuable reflective tool which clients can utilise for their own benefit. However, further research is required to investigate the most beneficial method for representing this data. The current study utilised a non standard graphing method for representing both the overall score and the individual domain scores, along with the individual domain cut off scores, at pre-therapy, post-therapy and follow-up. It may be helpful to simplify this system by dropping the domain scores completely, and utilising the new single overall ‘clinical score’ proposed by Barkham et al (2006). There may also be worth in indicating the severity levels to give clients a finer differentiation between scores other than just clinical or non clinical. Additionally, further research needs to be

undertaken in this area to discover if this approach is beneficial just at post-therapy, or whether clients would benefit from more regular ‘feedback’ on their progress throughout therapy.

The finding of the prevalence of response error was surprising to the researcher. The fact that 60% of respondents reported some form of response error during the study indicates that both practitioners and researchers who utilise the CORE-OM and similar measures would be wise to incorporate some form of dialogical component to the questionnaire administration. This would potentially allow at least the more obvious response errors to be flagged up and corrected. In the longer term, it would seem imperative that alternative methods of questionnaire presentation are explored. For example, Marshall and Willoughby-Booth (2007) devised a modified form of the CORE-OM to make it easier for people with mild learning disabilities to complete. Rather than rely on words alone, the authors devised a system of pictograms to complement the questionnaire items, and utilised a histogram style rating system rather than the standard anchor points. Alternatively, some instrument designers have adopted analogue scales rather than discrete points. Measures such as the Outcome Rating Scale (Miller et al., 2003) (see Section 2.1.6) present clients with a single continuous line which they are asked to rate themselves against. Though it is beyond the scope of this study to explore the pros and cons of these various approaches, it would seem an urgent area of further research, especially in terms of discovering more about the respondent’s experience.

A more complex issue arises in terms of addressing the problem of response shift and gamma change. Here the very nature of an objective measure that does not change over time becomes the issue. It would seem that quantitative measures such as the CORE-OM are incapable of ‘measuring’ such changes. However, as the current study has demonstrated, it is possible to discover the presence of response shift and gamma change through a dialogical process. At the item level, this would allow such data to be discarded from the scoring of the questionnaire to gain a more accurate mean score. However, if the gamma change is significant, it is likely to affect too many items to make this option feasible. This would suggest that including complementary forms of outcome assessment such as the LSM approach would give a more complete picture of outcome than using the CORE-OM alone.

Finally, the findings of the study highlight further limitations of the method in terms of subtly reinforcing differences in power and being of limited value as a collaborative tool for some participants. There is potential here that more individualised forms of outcome questionnaire such as the Simplified Personal Questionnaire discussed in the literature review (see Section 2.1.7) may counter these limitations by directly involving participants in their construction process. Not only would this inherently involve more of a collaborative process, it may also afford participants a greater sense of ownership and control.

8.4 Mapping as an approach to assessing change

The present study has demonstrated that it is possible to evaluate the outcomes of counselling and psychotherapy using a creative, visual approach within a clinical setting. Further, this approach appears to be of value not only as a research tool, but as a reflexive tool for clients themselves. The following section will outline some of the key findings which have emerged from the study in relation to the theory and literature, the participants' experiences of using the LSM approach, and the researcher's own experience. This will be followed by a discussion of the implications of these findings for the use of the LSM and ideas for the further development of the approach.

8.4.1 *Strengths, limitations and key features of the LSM*

8.4.1.1 Provides a point of reference for reflecting on change

The results of the study indicate that the LSM approach worked in terms of the original intention of the researcher to develop a method which could allow participants to reflect on the changes they had experienced over the duration of therapy. Participants reported that the LSM 'takes you back' (see 7.4.1.2.5), that it really captured for them how things were before their therapy began, and reminded them why they had sort counselling in the first place. This was significant as some participants reported that they had almost forgotten how bad things were before their therapy began. Participants also reported that the LSM allowed them to 'witness' change, 'like a film of your life' (see 7.4.2.2.3), that the approach enabled people to recall how they were when they first did their LSM, then 'fast forward' the film of their life to later on to see what had changed. The results clearly show that the LSM approach provided a specific reference point or 'marker' which allowed participants to 'see' change for themselves (see 7.5.1).

There is also evidence from the results that the LSM approach allowed participants to decentralise the significance of therapy in their change narratives. It would seem that asking participants about the differences between their Life Space Maps provides a different narrative account of change than asking someone "what has changed since therapy began". It appears that the LSM provides a reference point which allows a client to make direct comparisons between specific points in their life, rather than framing change 'around' their therapy as is the case with most post-therapy change interviews.

8.4.1.2 Making gamma change visible

The results from the study suggest that the LSM approach is particularly effective for assessing the outcomes of therapy when 'gamma change' has occurred (Golembiewski et al., 1976) (see Section 2.2.6). As noted above, quantitative measures such as the CORE-OM are not well suited to assessing change when there has been a redefinition of the psychological space. In contrast, the

LSM approach is ideally suited to making exactly these sorts of changes visible. Participants who reported seeing little differences in their CORE-OM scores (see 7.4.3.1.4) in contrast were able to identify small but important changes from their LSM (see 7.4.3.2.3). It would seem from these results that because each LSM is so unique and different, it can enable a participant to see subtle differences and shifts which would otherwise have been missed. Significantly, in one case it was not until the ‘seeing’ of the LSM that there was a realisation of how much had changed. This suggests that not only can the LSM be a useful tool for assessing gamma change as an outcome of therapy, but that it may also be a useful tool for clients themselves for discerning such changes.

8.4.1.3 Ecological validity

Additionally, the results indicate that the LSM approach can be seen to offer greater ‘ecological validity’ (see Section 3.2.3) for the assessment of therapy outcomes compared to either quantitative measures or qualitative interviews. It is evident from the thematic analysis that the LSM allowed the ‘idiosyncratic perception’ and ‘internal states’ (Bronfenbrenner, 1979) of participants to be brought to into awareness and revealed to the researcher more explicitly than would be possible with a questionnaire or even an in depth qualitative interview. Participants reported that the visual nature of the LSM enabled them to express things that words alone could not (see Section 7.4.2.2.1), that things come from ‘further down’ and could be expressed in a natural, fluid process that took them to places that they could not necessarily predict (see Section 7.4.3.2.2). Given the nature of the counselling process, it would seem the LSM offers a valuable method for allowing these non-verbal and less cognitive components to be incorporated into an assessment of outcome. From an ecological perspective, this is significant in terms of the research setting, including the measures used, being experienced by participants as allowing them to report the types of change expected by the researcher to ‘come out’ of therapy. Particularly with regard to therapies that theorise non-cognitive and less ‘rational’ components of change, the LSM would seem to offer participants a method which allows this to be visually represented.

8.4.1.4 Revealing less conscious components of outcome

The above results also suggest that the LSM has the potential to reveal less ‘conscious’ components of the outcomes of counselling and psychotherapy. Participants’ reported a sense of using a ‘different part of the brain’ (see 7.4.2.2.1) to complete the LSM, that there was more of a ‘natural flow’ like ‘letting your hand do the walking’ or drawing with the left hand (see 7.4.3.2.2). There is a suggestion here that the LSM may act somewhat as a projective technique (see Section 2.4.2) which can gain access the ‘hidden’ inner world of participants. This projective element may also have provided an opportunity for participants to see these more ‘hidden’ or less conscious aspects for themselves. Though there is some suggestion of this when participants reported ‘making connections’ or ‘putting things together’ (see 7.4.3.2.1), this was not explicitly checked out with participants and would require further research to ascertain.

8.4.1.5 Difficulties with the drawing task

Though the results generally show that participants valued the LSM approach, they also indicate that some clients may not be well suited to using a visual and creative approach for assessing outcome. A number of participants indicated that they found it difficult to put things on to paper (see 7.4.1.2.6), felt quite awkward expressing themselves ‘under the spotlight’ of the interview (see 7.4.2.2.4), or felt they were being asked to do something quite childish (see 7.4.2.2.5). This supports the caution raised by Deacon and Piercy (2001) (see Section 2.4.5) that participants more familiar with functioning in a cognitive and verbal manner may experience more creative ways of working as quite daunting, too revealing or just ‘odd’. There is also some evidence to support Oster and Gould’s (2004) warning that participants may even feel ‘regressed’ (see 7.4.2.2.5). It is clear from this data that care needs to be taken when using the LSM approach to not impose the task on participants. It also indicates the need for further research to see if alternative forms or more structured approaches to the mapping task are less inhibiting.

8.4.1.6 Potential for emotional distress

Additionally, the results of the study highlight the need to be aware of the potential for participants to experience emotional distress when using the LSM approach to investigate the outcomes of their therapy. Some participants described the mapping task as being quite ‘unboundaried’ (see 7.4.3.2.4), that there was potential to get a bit ‘lost’ in the process. Participants also reported that the mapping process put them in touch with feelings that could be quite unsettling (see 7.4.1.2.1), with one participant describing experiencing sleepless nights following their pre-therapy interview. Other participants expressed being worried about attending the post-therapy interview in terms of it ‘bringing things back up’ for them (see 7.5.3). Mitigating these concerns, participants also reported that they felt ‘in control’ of the process (see 7.4.1.2.2), that they did not feel forced to reveal any more than they wanted to. There are clear indicators here that care needs to be taken when using the LSM method to ensure participants are held sensitively and with awareness of potential difficulties throughout the process. As noted by participants, this highlights the importance of a facilitative and non-judgemental attitude by the researcher (see Section 7.5.4), both in terms of enabling people to feel safe enough to express themselves, and in terms of being supported through a potentially difficult and personally challenging experience. This concurs with Deacon and Piercy’s (2001) warning that the use of creative approaches to research needs to take into account the client’s psychological and physiological abilities to engage with the method, and that care needs to be taken in order to avoid putting clients at risk of harm (see Section 2.4.6).

8.4.1.7 A collaborative approach to assessment

The results from the study clearly demonstrate the value and importance of a collaborative approach to outcome assessment (see Section 3.5.4). The majority of participants reported that they had been able to use the research to ‘see change for themselves’ (see Section 7.5.1), that it had given them an opportunity to reflect on and construct meaning around their experience of therapy.

Further, there is evidence that participants engaged in a form of ‘hermeneutic cycle’ as described by Fischer (2000) when constructing their Life Space Maps. Participants reported that the act of putting things down on paper allowed them to ‘break it all down’ (see 7.4.1.2.4) rather than everything being a big haze. Once things were down on paper, participants reported that it made things more ‘tangible’ (see 7.4.1.2.3), that they could see things more clearly. This in turn seemed to allow participants to make connections between things and ‘put things together’ in a different way (see 7.4.3.2.1). Here it can be conceptualised that rather than ‘capturing’ a person’s experience, the LSM is more an evolving process, that the act of putting experiences down on paper also shaped their experience and gave new meaning to it. Hence the ‘outcome’ of therapy was both revealed in, and created by the very act of constructing the Life Space Map.

8.4.1.8 A different ‘picture’ of outcome

The results of the study suggest that the visual nature of the LSM can provide a mechanism whereby different ‘voices’ of outcome are able to be heard. Drawing on Peavy’s (1999a) conceptualisation of life space mapping as a shared ‘cultural tool’ which can be used to make sense of and communicate experience (see Section 3.6), the visual nature of the LSM allowed different ‘stories’ to be ‘told’ by participants and ‘heard’ by the researcher than would be possible using a non-visual approach. For example, participants reported that the LSM was like seeing a ‘photocopy of the brain’ (see 7.4.1.2.5), or a ‘film of your life’ (see 7.4.2.2.3). Here participants reported that the imagery of the LSM ‘speaks directly to you’ and ‘hits you in the face’ (see 7.4.2.2.2) rather than needing to be interpreted or calculated, that the overall colours, layout and complete image had meaning to them which was different from its individual parts. These visually inspired metaphors and narratives can be seen to have shaped the ‘picture of outcome’ that was obtained from the interviews. This has in turn shaped the ‘image’ which has been communicated to the reader. Significantly here, the ability to include reproductions of participants’ LSMs allows a different form of communication than the written word alone, which potentially gives clients a more direct and unedited ‘voice’ than would otherwise be possible.

8.4.1.9 The importance of retaining the client’s frame of reference

The results of the study strongly confirm the importance of evaluating change from the client’s own frame of reference (Rogers, 1951a; see Section 3.4.4). In the presentation of the montage of Life Space Maps (see Section 7.3), it is clearly evident that the client’s own narrative is imperative to understanding the significance of individual LSMs, and the differences between them (see, for example, Section 7.3.4). Further, the thematic analysis revealed that there is ‘more to it than meets the eye’ (see 7.4.1.2.7), that there is often a lot of hidden meaning behind the LSM that can only really be understood by the person constructing it. This indicates that any attempt to interpret individual LSMs or evaluate the significance of differences between them without at least a contextualising narrative should be avoided. Wherever possible, change should be evaluated by the client themselves, rather than be construed or judged from an external perspective.

8.4.1.10 Client agency and reflexivity

The study strongly confirms the view of clients as being active agents able to use whatever resources are at hand to further their growth process (Bohart & Tallman, 1999; Rennie, 1994a; see Section 3.5). The case study offers a clear example of a participant using multiple resources alongside their therapy (see Section 7.1.4.3), of making use of ‘anything at hand’ in their healing process. Further, participants’ reflections on their experience of the research project indicate that people also used the actual research interviews as a therapeutic tool throughout the study (see Section 7.5.2). Rather than the research being a passive or neutral encounter, participants actively utilised the process for their own purposes. This suggests the value of research methods that also facilitate this client agency, and enable them to actively utilise the research itself as part of their healing process. Here the LSM would seem to be a powerful tool in this respect, that it encourages self reflection and creates an opportunity for clients to discover new things in the process.

8.4.1.11 Lewin’s developmental dimensions of the life space

The results from the study suggest that the LSM approach is able to evoke rich narrative accounts of change from therapy which can be conceptualised along the dimensions of development of the life space as hypothesised by Lewin (1952; see Section 3.1.5). Specifically the dimensions of *differentiation*, *restructurization*, changes in *time perspective*, and changes in the degree of *reality/irreality* can be seen to provide potentially valuable constructs for evaluating the outcomes of therapy. For example, the case study reveals an apparent shift in the *time perspective* of the participants’ problem narratives over the duration of therapy, from being narrowly focused on specific issues to having a broader ‘worldly’ view of problems at post-therapy (see Section 7.1.7.1). Similarly, the causes of problems appear to become more *differentiated* as time progresses, with a more complex conceptualisation of the participant’s depression emerging (see Section 7.1.7.2). Within the client’s own change narratives, something akin to Lewin’s *restructurization* can be seen to have taken place, whereby the participant talks about ‘letting go’ of the past instead of being rigidly ‘locked’ in it (see Section 7.1.7.4). Though this potential looks promising, further analysis of existing data and ongoing research is required to confirm this (see Section 8.4.3).

8.4.1.12 Changes in the client’s ecological environment

There is some evidence from the study to indicate that the LSM was able to explore the outcomes of therapy in terms of Bronfenbrenner’s (1979) conceptualisation of the ecological environment (see Section 3.2.1). Within the montage of LSMs (see Section 7.3), it can be seen that a number of participants referred to aspects of their micro and meso systems (see, for example, Figure 7-16), incorporating representations of various ‘systems’ such as family, work, social life etc. This potentially allows the outcomes of therapy to be evaluated in terms of changes in a client’s ecological environment rather than being seen purely as a function of the individual in isolation.

Additionally, in the case study attribution narratives, the participant relates numerous influences that have interacted with her therapy to affect the ‘outcome’, such as reduction in financial pressures, changes in medication, exercise and socialising, and Buddhist meditation (see Section 7.1.7.5). Here counselling was seen as only one of many resources on a ‘list’ which the participant utilised within their life space. This indicates that the LSM approach allows a more complex and interdependent investigation into therapy outcomes, rather than assuming a direct ‘cause and effect’ model of change from a discrete and independent ‘intervention’.

8.4.1.13 Interactive effectiveness and the personal niche

There is some evidence from the study that the LSM approach may be useful for assessing changes in therapy in terms of ‘interactive effectiveness’ and the ‘personal niche’ (Willi, 1999) (see Section 3.3.4). Rather than evaluating purely psychological change (e.g. in depression, anger, stress etc), the LSM approach allowed some participants to depict ‘real’ objects with which they interacted. Further, the LSM seemed to allow some participants to depict different elements of their personal niche, and how their interaction within this changed over time (see, for example, Figure 7-12). However, other participants utilised the LSM approach in an entirely abstract manner without relating to any ‘real’ objects at all (see, for example, Figure 7-14). This suggests that while the LSM approach could be used to explore Willi’s concepts of the outcomes of therapy, it would require further refinement. In particular, the LSM instructions would need to be focused more specifically on instructing clients to only include ‘real’ objects with which they interacted. However, while this would allow the method to be more directly aligned with Willi’s theory, it might well limit some clients from fully expressing themselves in other ways.

8.4.1.14 Changes in the client’s perceptual map

There is clear evidence from the results that the LSM approach allowed participants to ‘see’ changes in their perceptual map over time (Rogers, 1951b; see Section 3.4.3). The case study poignantly illustrates an example of the LSM approach allowing a participant to see how distorted their perception had been at pre-therapy (see Section 7.1.9). Further, the montage of Life Space Maps (see Section 7.3) demonstrates examples of ‘perceptual shift’ such that how a participant portrayed their LSM altered significantly over time (see, for example, Section 7.3.5). Additionally, participants reported being able to retrospectively ‘see’ things in their LSMs that were previously unavailable to their awareness, and to ‘fast forward’ through how their view of things had changed over time (see 7.4.2.2.3). These results indicate that the LSM is a valuable tool for revealing a clients changing symbolisation over time. Here there is also potential to further investigate Rogers’ (1951b) theories of perceptual reorganisation as an outcome of therapy.

8.4.2 Implications for using the Life Space Map approach

The above findings have a number of implications in terms of utilising the LSM approach for the assessment of counselling and psychotherapy outcomes. In particular, as a direct contrast to the CORE-OM, the results indicate that the LSM approach is well suited to making gamma change visible and apparent. Conversely, the LSM approach is not well suited for measuring alpha change, as it does not provide an easy way to make direct, linear comparisons between pre and post-therapy. As suggested in the discussion of the CORE-OM, this fact indicates that the two approaches may work best as complementary methods, rather than as competing forms of outcome assessment. Indeed one of the key findings to emerge from participants' reflections on the study was that each method 'informed' the other and provided different parts of the puzzle.

In terms of developing a qualitative approach to outcome assessment, a key theme to emerge in the findings was the 'added value' of the visual component of the approach compared to standard qualitative interviews. In particular, the LSM gave participants a direct reference point to how things were for them at the beginning their therapy, rather than relying on their retrospective recall alone. This is particular significant as by the end of therapy, some participants reported having forgotten how bad things were, and the LSM was a stark reminder of why they had come for counselling in the first place. Additionally, this facilitated the participants own 'seeing' of change, that it allowed them to 'witness' the changes in their life for themselves.

Further, the ability of the LSM to reveal less conscious components and to provide a different 'picture' of outcome is significant in terms of improving the ecological validity of any studies proposing to investigate therapies that contain non-verbal and non-cognitive change components. Rogers' (1951b) theory of perceptual reorganisation and Willi's (1999) concepts of interactive effectiveness and the personal niche discussed above are just two examples where research using an LSM approach would potentially offer greater ecological validity than either traditional quantitative questionnaires or qualitative interviews. Researchers investigating other non-cognitively based therapies may find the LSM an effective tool for revealing aspects of outcome which would otherwise be missed by more cognitively based methods. In particular, researchers investigating humanistic therapies may find the LSM approach a valuable tool for overcoming some of the issues raised by Levitt et al (2005) in terms of 'using thermometers to weigh oranges' (see Section 2.2.4).

Similarly, researchers interested in investigating change relating to a client's wider 'life world' may find the LSM approach valuable. The findings from the study indicate that this approach may enable changes in a person's ecological environment to be identified. With regard to therapy outcome research, the LSM approach seems to be particularly valuable for decentralising the focus on counselling or psychotherapy as the primary change factor, and instead revealing the complex network of resources and social tools which a person has drawn upon. There is also some evidence

that the LSM method may reveal change in the life space along the developmental dimensions hypothesised by Lewin (1952).

Another key finding to emerge from the study relates to the ability of the LSM approach to tap into and reveal the extensiveness of client agency and reflexivity. It would appear from this study that the LSM is inherently reflexive in nature, that the actual process of constructing a Life Space Map 'requires' people to collaborate in a form of 'hermeneutic cycle' (Fischer, 2000). People can not just respond to some external stimuli, be it a questionnaire item or an interviewer asking a question. Rather, the drawing process requires a continual 'flow' between 'mind', 'hand' and 'eye'. A thought arises in the 'mind' which instructs the 'hand' to begin to draw, yet as soon as the drawing begins it registers on the 'eye', which in turn alters the 'mind'. There is also a sense here that 'mind' is not just 'consciousness', that the processing of seeing something on paper can trigger links and connections to things that were not part of the original thought process. Hence the LSM approach may offer a powerful method for studies investigating aspects of client reflexivity by utilising a tool which directly taps into that which is being investigated.

A cautionary note needs to be raised here though as it is also evident from the above findings of the study that care needs to be taken in utilising the LSM approach. People may feel unfamiliar and uncomfortable with this form of expression and may find it too 'exposing', or even 'regressing'. For others it may be emotionally quite painful and potentially overwhelming as the process connects them with 'unprocessed' feelings and emotions, or opens things up which were previously held out of consciousness, especially at the pre-therapy stage. Here it can be helpful to bring participants back to the drawing task, and to remind them that a counsellor will be able to go into things with them in more depth. Within the present study, the significance of a person's Life Space Map was understood from their own frame of reference as much as possible, using a dialogical approach, rather than being 'interpreted' or 'analysed' from a purely external perspective. It may be that a more interpretive or 'neutral' stance on the part of the researcher, may be experienced as more threatening by participants.

On a practical note, it should also be noted that a further issue with the LSM approach is the length of time that the mapping process consumes. Maps typically took 15 to 60 minutes to complete, with the potential for added time for reflection on changes from pre to post-therapy. Additionally, issues arise in terms of the recording and storage of maps, especially if large A1 or A2 sheets are used. Finally, interviewers need to be aware of limitations in recording devices, such that if only audio recordings of interviews are used, it can be useful for the later transcription of recordings for the researcher to explicitly identify in words what a participant is implicitly referring to or pointing at.

8.4.3 Further development of the Life Space Map approach

The current study has revealed a number of areas for future development of the Life Space Map approach. In particular, a common difficulty expressed by participants in the current study revolved around starting the mapping process from a 'blank canvas'. There is potential to investigate the option of using some of the more structured approaches to mapping discussed in the literature review (see Section 2.4.5), such as node-link mapping or eco maps. Similarly, a more structured approach to the LSM interview whereby instructions were provided that invited people to depict different emotionally meaningful aspects of their life space (e.g. 'your home', 'your family', 'the problem', etc.) may prove beneficial in this regard. It would also be possible to show clients images of maps that have been completed by others (for example, see Figure 6-2). Additionally, alternative forms of mapping 'technology' could be investigated. In particular, alternatives to 'paper and pencil' drawings could be explored such as 'tablet' style computers. Interviews could be video recorded as opposed to just audio recorded in order to capture more of the dynamics of the mapping process itself.

Another area of further investigation would entail the possibility of incorporating mid-therapy, or even weekly Life Space Map interviews. This may provide participants with additional opportunities for self reflection, as well as additional 'data points' for analysis. However, this may also add an undue burden on participants. A more structured approach to the mapping task as suggested above may help in this respect. Another option would be to invite participants to complete Life Space Maps at home, at a time of their choosing, thus using the LSM as a form of 'visual diary'. These could be compiled by the client into a 'portfolio' and brought along to the next research interview for discussion and reflection on the client's change process.

Further development also needs to be done in terms of establishing potential frameworks for analysis of change in client narratives over the course of therapy. Though the framework used in the case study of 'problems', 'causes', 'resources', 'changes' and 'attributions' seemed sufficient for this case, further investigation is required to determine whether or not alternative conceptualisations would reveal different dimensions of outcome. For example, there is potential to use Lewin's conceptualisation of developmental dimensions of *differentiation*, *restructurization*, changes in *time perspective*, and changes in the degree of *reality/irreality* of the life space as a primary organising structure for a participant's narrative rather than the approach taken in the current study. Here it would be possible to construct a coding framework or rating scale that embodied Lewin's constructs, or to use the ideas in a more open-ended hermeneutic fashion.

In addition to analysing changes in narrative, there would also seem potential for developing methods for directly evaluating change in various aspects or dimensions of a client's Life Space Maps. This would allow more systematic comparisons to be made both over time and between participants. Possibilities include using Lewin's dimensions of development discussed above, or

utilising existing forms of art therapy evaluation. For example, keywords from the descriptive accounts of Lewin's dimensions (see Table 3-1, Table 3-2, Table 3-3, and Table 3-4) such as 'Unstructured', 'Unclear', 'Vague', 'Linear', 'Static', 'Rigid', 'Disjoint', 'Disorganised' etc versus 'Differentiated', 'Dynamic', 'Fluid', 'Complex', 'Interconnected', 'Integrated', 'Organised' etc could be utilised to construct a rating tool of the degree of differentiation, restructurization, time perspective and level of reality of a person's LSM. Alternatively, existing methods for quantitatively evaluating drawings could be used such as the Formal Elements of Art Therapy Scale (FEATS; see Section 2.4.3). Here it would be important that any such evaluation is done in a collaborative manner in order to maintain the idiographic and client centric nature of the method, rather than being applied in a reductive, essentialist fashion which imposes interpretations from a purely external perspective.

8.5 The use of outcome assessment in case study research

An important emergent theme within the study concerned the role of outcome assessment in the context of systematic case study research (McLeod, 2010, in press). In contrast to group-based studies in which data is aggregated over several participants, research that employs a Hermeneutic Single Case Efficacy Design (HSCED) (Elliott, 2002) or similar approach to systematic case inquiry carries out a detailed comparison or 'triangulation' of the data for one participant. The findings of the present study have a number of implications for the design and conduct of such single case studies.

8.5.1 The value of the LSM as a case study tool

The use of the Life Space Map in combination with the CORE-OM proved to be a particularly valuable method for constructing an in-depth case study. Further to 'visually enhancing' the write up of the case study, the depth of engagement of participants with the Life Space Map allowed a detailed exploration of clients' changing views and problems over the duration of their therapy, and at follow-up. Further, the visual and 'hands on' nature of the LSM facilitated each participant's own exploration of things during the process of the research interviews. As such, interviews were more than just data gathering tools, but rather a collaborative and highly reflexive 'hermeneutic cycle' (Fischer, 2000) that helped to construct the 'view' of outcome that clients were left with.

Further, the LSM proved a valuable method for creating a reference point for participants to refer back to, rather than having to rely on their retrospective recall. This differs from most qualitative change interviews which typically rely on participants' memory of how things were before therapy began (see Section 2.3.3 of the literature review for a discussion of a standardised change interview

typically used in the HSCED method). Using the LSM approach, participants could literally ‘see’ how things were for them prior to therapy, and ‘witness’ how things had changed. As such, the LSM approach potentially offers a more powerful method for evoking change narratives than interviews that do not have this visual pre-therapy reference point.

The findings of the study also highlight the potential of the LSM approach to reveal non-verbal and less ‘conscious’ components of outcome, and of allowing these to be seen by both participants and researcher. This again has the potential for evoking richer narratives of change than purely spoken interviews by providing a different ‘cultural tool’ (Peavy, 1999a) for both participant and research to communicate through. It can also be argued that participants can only reveal the types of change that a given cultural tool ‘affords’ them. Hence quantitative questionnaires and spoken change interviews will inherently limit the type of ‘outcome’ that can be seen to more linguistic based components. Use of visual methods such as the LSM may allow case study researchers to explore components of therapy outcome that these traditional methods have not so far revealed. This also has significance in terms of the ecological validity (Bronfenbrenner, 1979) of case study research into forms of therapy which predict less conscious and non-verbal changes. Here it can be argued that tools which directly access these components of outcome have greater ecological validity than ones which just ‘ask’ about them.

Finally, the LSM approach seems to focus participants more on their own ‘life space’ than on the ‘therapy space’. It would appear this has the effect of eliciting change narratives which are located more fully within a client’s everyday lived experience, rather than within the therapy room. Even more significantly, participants’ reflections on what they attributed change to seemed to be more embedded in their own ‘life space’ as well. From a participant perspective, this may give a truer representation of the place of therapy in their change process, and allow a more complex and interdependent view of the role of counselling and psychotherapy in a client’s life.

8.5.2 The issue of participant idiosyncratic interpretation of questionnaires

Though the study reveals the potential of the CORE-OM as a reflective tool for participants, it also highlights the regularity with which questionnaires are misinterpreted. This has more serious implications for case study research than group designs where any ‘response error’ will be averaged over the group. With case study research, there is a much greater reliance on not only individual questionnaires being completed accurately, but also individual items being interpreted correctly. From the findings of the current study, it is obvious that participants do not find the process of completing a questionnaire as straightforward as researchers think it is. Participants may simply misread items, may interpret them in a completely different context, may cover up how bad they are feeling, or may not be in any mental state to be able to really engage with the process. Further, even when the actual items are understood, participants appear to have quite varying

interpretations of the Likert scales commonly used on questionnaires. It is very clear from the results of the current study that participants do not perceive these scales to be uniform intervals, and that different participants associate very different 'values' to the anchor points.

These issues may be of minor importance in large scale studies, where it could be argued that 'measurement error' averages out over the whole sample. However, idiosyncratic item interpretation is a more serious issue in the context of case study research, in which each item of data for a participant can have implications for the interpretation of the case as a whole. Hence it would seem imperative that case study researchers do not assume that how a participant has responded to a questionnaire is exactly as they had intended them to. Engaging participants in a dialogical process would seem a valuable way of checking out the participant's idiosyncratic understanding of questionnaire items, and their ratings. There is potential here to identify some, but not all of the potential response errors identified above, as issues of trust and cognitive capacity are unlikely to be revealed. Further, it is apparent from the current study that some 'response errors' are actually representative of 'response shift' or gamma change. Here the interpretation of an item may not match that of the researcher, but it never the less represents an 'accurate' response from the participant's perspective.

Though the above dialogical enquiry may go some way to addressing the problem of idiosyncratic item interpretation, this can not address the more fundamental issue of the idiosyncratic interpretation of the Likert scales. Here the assumption of linearity and common meaning is inherent in the scoring systems of questionnaires, as well as the normative data used to generate clinical cut off points, severity levels, reliable changes indices etc. This would seem to require a more fundamental redesign of questionnaires to improve the communication between questionnaire designer and respondent (see Section 8.3.2 above for a brief discussion of alternative questionnaire designs).

Given the above, it would seem prudent that researchers employ contrasting and complementary tools for investigating the outcomes of counselling and psychotherapy on a single case basis. The LSM approach utilised in the present study would seem to offer one such option. Not only would this approach potentially reveal situations where 'response shifts' have occurred, it would also allow the researcher to gain a better understanding of the potential meanings that a participant has intended to communicate, and afford an opportunity for this to be checked out explicitly.

8.6 The role of outcome measures in enhancing the effectiveness of therapy

An important recent development in counselling and psychotherapy research and practice has been the use of outcome measures as a means of providing feedback to clients and therapists about the on-going effectiveness of therapy (Lambert, Hansen et al., 2001; Lambert, Whipple et al., 2001; Miller, Duncan, Sorrell et al., 2005) (see, for example, Section 2.1.4 of the literature review for a brief discussion of the ‘signal alarm’ system in relation to the OQ-45). The present study offered a unique opportunity to explore the client’s perspective on the value of different types of data-collection tools in relation to providing them with feedback on the outcomes of their therapy.

8.6.1 *Research tools as potent interventions*

The results of the current study clearly demonstrate that participants experienced the CORE-OM and the LSM as an active intervention, rather than being passive or neutral. Participants were able to use the CORE-OM as a checklist of commonly experienced problems and issues, to see that what they were going through was not unusual, and take the opportunity to ‘check in’ with themselves. The LSM gave participants a space to express themselves, to ‘break things down’ and ‘get things down on paper’ so that things became clearer and more tangible, affording the opportunity to put things together differently and allow new understanding to emerge. Both these processes are potentially affirming and beneficial, and provide the opportunity for therapeutic growth.

Indeed for one participant in the study, the research interviews were reported to be a lot more beneficial than their actual counselling (see Section 7.3.1). Though emotionally upsetting, the pre-therapy interview gave this participant space to really see what she was struggling with in her life. Further, her post-therapy interview gave her a chance to talk through her experience of feeling dismissed and belittled by her therapist. This again demonstrates the active nature of the research processes when conducted in a collaborative, facilitative manner (Fischer, 2006b). This finding is similar to other researchers who have discovered that their interviews are potentially more therapeutic than the therapy they are investigating (Gale, 1992).

8.6.2 *Assisted reflexivity*

A significant finding from the study was the value participants placed on having a method which assisted them to reflect on the changes that had taken place for them. This was true of both the CORE-OM and LSM methods. Participants reported benefits from seeing their CORE-OM graph, and their Life Space Maps side by side, which assisted them to see the changes in their life. Here it

would seem that the value was in the way that the methods were used, that participants valued the opportunity to reflect on the changes from their own perspective, and that different methods afforded different ways to do this.

Here the method used can be seen as a form of ‘assisted reflexivity’. Rather than being asked once to ‘say how it was’, either in a questionnaire or a qualitative interview, the method assisted participants to recall and reflect on change. This finding is not exclusive to the present study as it would appear that other qualitative outcome researchers are also discovering the value that participants find in being provided with explicit points of reference to assist their recollection and reflection on change. For example, the following quote from Hardtke and Angus’s (2004) account of their experience of using the Narrative Assessment Interview (see Section 2.3.4 of the literature review) nicely captures this sense of active meaning construction through the research interview:

...by creating a context for focussed self-reflection on experiences of difference and change, the Narrative Assessment Interview protocol functions as an effective therapeutic intervention. By stimulating clients’ to provide meaningful accounts of experiences of shifts or changes in their perspectives on self and others – and to ground those new views of self in storied representations of lived experiences – the Narrative Assessment Interview contributes to the identification of what Michael White terms ‘unique outcome stories’ and the inception of new plot lines for client’s life narratives. (p. 260)

The findings of the present study corroborate this account, and suggest that the LSM approach offers additional benefits in terms of providing a medium which evokes further dimensions of reflexivity such as ‘spatiality’, ‘metaphor’, and ‘imagery’ that other purely numeric or verbal methods may not. This concurs with the view of others utilising creative, artistic approaches to research who argue that the evocative nature of pictures and drawings allows a more vivid recall of details than other methods (see Section 2.4). Further, art therapy researchers such as Schaverien (1993) contend that images not only allow more vivid recall, but facilitate a more visceral process of affect and emotions from the past being carried ‘live’ into the present (see Section 2.4.3). In terms of assisted reflexivity, the LSM can be seen to assist participant’s recall at multiple levels, tapping into both cognitive and affective processes, and allowing more complex dynamics of change to be contemplated and reflected upon.

8.7 Implications for practice, research and funding

This section of the chapter looks beyond the findings of the study, and considers their implications for the practice, training, research and funding of the field of counselling and psychotherapy.

8.7.1 *Implications for practice*

There is strong evidence emerging from the current study that clients value the opportunity to reflect on change, that this is affirming and enabling. There is a challenge here for practitioners to become more open to integrating some form of ‘measurement’ or methods into their practice that assist clients to reflect on the overall nature of their experience (see Assisted Reflexivity above). Numerous clients in the study reported that they had forgotten how things were before their therapy began, or thought that not much had changed. Being able to actually ‘see’ how much had changed, either on the CORE-OM graph or the LSM, was empowering and affirming, even when the change was not necessarily positive.

This has immediate implications for the many counsellors and psychotherapists that are currently utilising the CORE-OM and similar measures to evaluate their practice. Rather than this being purely for data gathering purposes, the findings of this study strongly indicate that there is therapeutic value in offering this data back to clients in a way that they can make sense of things. Indeed, it could almost be argued that not doing so is equivalent of ‘withholding’, or denying clients access to something that is rightfully theirs. This also has implications for counselling agencies, research clinics, the NHS, and other organisations that regularly collect outcome data for monitoring purposes. Rather than employing outcome measures for the benefit of the organisation, the results from the current study challenge such practices as being potentially ‘selfish’ or promoting self interest above the potential benefits to clients.

8.7.2 *Enhancing the client’s experience*

The study clearly reveals how research interventions can be experienced as therapeutic. Far from being ‘intrusive’ or ‘sabotaging’ of the therapeutic process, clients generally found the research helpful and sometimes therapeutic in its own right. Indeed in one case, the research interview was experienced as more therapeutic than the therapy! Such findings are not unique to this study, with more and more ‘research on the research’ indicating the potential for research to support the therapeutic process when conducted in a collaborative and respectful manner. When utilised in this way, the current study supports the view of Fischer (2000; 2001) that standard assessment and outcome procedures such as completing the CORE-OM have the potential to help clients more fully explore their ‘life world’, and to actively construct meaning from their experience (see

Section 3.5.4). This indicates the potential value of routinely incorporating the collaborative use of outcome measures into the practice of therapy in order to enhance the client's experience.

In particular, the Life Space Map approach would seem to provide a valuable method for assisting clients' reflexive processes. Here the results of the current study support the contention by Peavy (2004) that Life Space Mapping offers clients a valuable tool for clarifying and simplifying complex circumstances, creating new insights and ideas, identifying strengths and barriers, serving as a plan for action, revealing influences and patterns in a person's situation, revealing important relationships and connections, making the self visible, and contextualizing a person's concern (see Section 3.6.4). In this way, Life Space Mapping may provide an invaluable tool for clients as an integral part of therapy to help them make sense of what is happening in their life.

8.7.3 Implications for training

The above implications indicate that further attention needs to be given to training counselling and psychotherapy practitioners in collaborative forms of outcome assessment and evaluation. For training programmes that tend towards a more evaluative, 'data gathering' approach to outcome assessment, attention needs be directed towards the use of collaborative methods such that clients can experience the process as being more interactive, and potentially beneficial in its own right. Conversely, for training programmes that tend to downplay or even discount the value of outcome assessment and evaluation, attention needs be directed toward informing trainees of the potential value that clients can find in these processes when done in a collaborative and respectful manner.

Further, such collaborative forms of outcome assessment and evaluation may prove valuable in terms of the training programme itself. In particular, participants on a training programme may find the Life Space Mapping process a valuable tool for reflecting on their development over the duration of their course. Not only could this provide a specific reference point at the beginning of training upon which to reflect on at the end of the course, but it may prove a valuable developmental exercise in its own right. This potential of Life Space Mapping is currently being pursued in a research project exploring the learning and development of counselling trainees at the University of Cumbria where the approach is being used to facilitate students' personal reflection and learning as well as a tool for monitoring change in their life space over time (L. Sugarman, personal communication, December 2nd 2009).

8.7.4 Implications for research

The findings of this study indicate that 'best practice' for studying the outcomes of counselling and psychotherapy is to use a mixture of quantitative and qualitative methods in a collaborative and respectful manner which promotes and encourages client agency. Not only is this experienced as

empowering and valuable to the participants themselves, it also facilitates an atmosphere of trust such that participants feel safe enough to potentially reveal less desirable or more difficult aspects in relation to the outcomes of their therapy. Further, the study indicates that outcome data should be offered back to clients in a way that assists their reflexivity (see Assisted Reflectivity above) and allows them to make use of the data for their own growth process. This finding has both practical and ethical implications. It challenges the profession to find ways of integrating this feedback into regular research practices. More significantly, it calls into question the regular practice of not doing so as 'unethical', as not living up to the ethical principles of fidelity, autonomy, beneficence or even justice as prescribed by the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP, 2009).

This finding also calls for more research into the client's experience of utilising standardised quantitative questionnaires. Though this study provides a fascinating insight into how clients made use of one such measure, further research should be undertaken into participants' experiences of different types of measures used in different ways. For example, does the use of ultra brief outcome measures (see Section 2.1.6) limit the opportunity for clients to 'check in' with themselves? Similarly, are personalised outcome questionnaires (see Section 2.1.7) inferior to standardised questionnaires in terms of providing a checklist of commonly experienced problems? How is the use of regular weekly outcome measures experienced compared to purely pre/post-therapy measures? What differences do participants experience in terms of being provided feedback on a regular weekly basis versus just at the end of their therapy? These are just some of the many research questions that could be investigated to further our understanding of how clients make use of routine therapy outcome research and evaluation methods.

Additionally, the study reveals the value of visual methods for the field of counselling and psychotherapy outcome research. Going beyond the use of 'illustrated case studies', the results indicate that visual methods have the potential to offer greater ecological validity by accessing components of change that non-visual methods cannot. Further, such methods offer participants themselves an opportunity to reflect on change from a different 'view', and can provide an evocative and sometimes startling reminder of how things once were. The LSM approach in particular appears to offer a method which promotes participants' reflections on outcome that are more orientated towards to own 'life space' rather than attributing change exclusively to therapy. This offers the potential to gain a more 'client centric' view of outcome compared to traditional research methods.

8.7.5 Implications for funding

The findings of the study also have a number of implications for the funding of counselling and psychotherapy practice and research. In particular, the study calls into question the solidity of the

‘evidence base’ upon which many funding decisions are made in terms of the underlying data being an accurate representation of clients’ actual experience. The present study clearly demonstrates the significance and prevalence of ‘response error’ (see Section 2.2.5) and the potentially distorting effect of clients’ idiosyncratic interpretation of quantitative questionnaires on the data obtained. While it may be argued that group designs are specifically intended to ‘cancel out’ this ‘random error’, it is also apparent that some of these ‘errors’ have real and specific meanings to participants. In this respect, qualitative approaches to outcome assessment offer the potential to reveal these ‘hidden’ components of outcome, and to explore the complex, interdependent interactions between the client, their therapy, and their life world. Here the use of the Life Space Mapping approach to outcome assessment utilised in the present study was able to reveal important aspects of ‘outcome’ from the participants’ perspective that were just not accessible using a standardised quantitative approach.

Given the above, it would seem imperative that funders begin to look more seriously at ‘patient centred’ practice and research. Even though standards for the development of practice guidelines state that “it is also important to include outcomes that are important to patients, rather than focusing entirely on clinical outcomes” (SIGN, 2008, p.30), these same standards openly admit that “at present, there is no mechanism for incorporating [qualitative] studies in the evidence base” (SIGN, 2008, p.37). This situation would no longer seem tenable given that qualitative methods such as the LSM approach used in the present study have proven to be much more capable of accessing the client’s perspective of what is significant and important in terms of the outcomes of therapy than traditional quantitative methods.

Additionally, the current study clearly indicates the potential ‘added value’ of incorporating additional interventions ‘around’ existing therapeutic practices. Rather than focusing on which type of treatment to recommend for which type of presenting problem, there is potential here to look at generic methods for improving ‘therapy’ per se. Lambert and colleagues’ (Lambert, Hansen et al., 2001; Lambert, Whipple et al., 2001) signal alarm system is a case in point, where this approach has proven valuable for improving outcomes of clients at risk of deterioration regardless of the approach of the therapist. Similarly, the findings of the present study of the value to clients of being provided with a tangible reference point with which to evaluate their change from before to after therapy would seem to be applicable to all forms of therapy. The implication here is that greater funding of generic initiatives for improving therapeutic practice would yield more significant returns than continuing to fund research and practice which promotes continued ‘infighting’ between various therapeutic traditions.

8.8 Final conclusions

The Life Space Map approach seems to offer the potential for clients to situate their reflections on change within their own lived world. This has the implication that within the research interview, there is an 'indwelling' within the client's own 'life' and their own 'space'. This is possibly the unique contribution of the LSM approach to therapy outcome research. In relating their experience of 'change', clients are relating it from this indwelt place. Further, they are not relating their experience of 'change from therapy', but rather their experience of 'change in life'. Additionally, clients are not only able to 'tell' us about how things have changed, they can also 'show' us. It would seem from the results of this study, that these factors combine to allow us to 'see' a very different picture of the outcomes of therapy than we usually have access to, that the method affords us an opportunity to 'see it from the other side'. I hope this potential is taken up in one form or another by others interested in learning more about this 'other side' of therapy outcomes. Perhaps then as a profession, we can begin to really move forward from trying to 'prove' that therapy is effective, towards finding ways that let us hear as fully as possible about the complex, multifaceted, painful, disappointing, joyful, enlightening, heart breaking and humbling journeys of life that our clients have to tell us... if only we let them!

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APPENDIX A: Counsellor Information Sheet

A study is currently being undertaken at the Tom Allan Centre to explore the changes that people experience in their life from coming to counselling. This research is being conducted by Brian Rodgers as part of his PhD studies at the University of Abertay Dundee. The study will be supervised by Professor John McLeod of the Tayside Institute for Health Studies. Further details of the study are available on the sheet titled "Life Space Mapping Project Information Sheet".

At this stage, Brian is looking to recruit prospective clients who might be interested in participating in the study. This will involve the person being interviewed by Brian before their counselling begins, again when counselling finishes, and finally about 3 months afterwards. Each interview will last approximately 1 hour and will be held at the Tom Allan Centre.

For the recruitment phase of the study, an Information Sheet and Contact Consent Form (see attached) will be included in the documentation given to people who come for an intake interview at the centre. I would greatly appreciate it if you would draw people's attention to this and assist in retrieving the completed consent forms. A ducat will be assigned in the main office area for forms to be returned to, so if a person hands you the form, please place it there.

As Brian needs to interview participants at the end of the counselling, when you stop seeing a client, can you please ensure that you close the case promptly and put your case notes in Fiona's ducat.

I thank you in advance for your assistance with this project. If you have any concerns or queries regarding the study, please contact myself at the address below, or contact my research supervisor, John McLeod, at the Tayside Institute for Health Studies, University of Abertay Dundee [REDACTED].

Alternatively, speak to the centre manager, [REDACTED], and she will pass your message on to me.

Kind regards,

Brian Rodgers
[REDACTED]

APPENDIX B: LSM Project Information Sheet

This research project is being undertaken by Brian Rodgers from the University of Abertay Dundee as part of his PhD studies under the supervision of Professor John McLeod. The research is designed to look at people's perception of the changes that take place from before till after attending counselling.

Before participants start their counselling, they will be invited to attend an interview where I will ask them to draw a picture of how they see their life just now. To help with this, I will guide people through the construction of a 'life space map'. This is a diagram that shows the significant things in a person's life and the relationships between them. Participants will also be asked to complete a standard pre counselling CORE questionnaire. This is a two page questionnaire consisting of 34 questions which can be responded to on a scale of 0 to 4.

After finishing counselling, I will again interview people and ask them to draw a life space map of how they see things then, and to complete a post counselling CORE questionnaire. I will then show participants their initial map and questionnaire, and ask them to comment on any changes that they see, why they feel things have changed and what they feel has allowed these changes to occur.

Approximately three months after people have completed counselling, I will contact them to arrange a follow up interview, where I will again ask them to draw a final life space map and complete a final CORE questionnaire. I will then show people their previous maps and questionnaires, and ask them to comment on any changes they see. I will also ask participants some questions about their experience of participating in the research, and check that they are still okay with me using the interview material in my research.

All interviews will be audio recorded and the life space maps will be retained by me to assist in the analysis process. Excerpts from the interviews and the life space maps may be used in the final report of the results of the project, and may be published as a research paper. Any personal details or identifying information will be disguised to protect people's identity. Participants may also request for specific details to be omitted, and to see the final report before it is submitted. Any material collected during the study will either be destroyed, returned to the participant, kept by the researcher or made available for further research according to wishes of the participant. Unless explicit consent is given, this material will not be used in any other study.

Please note that the research project is being conducted independently from people's counselling. Counsellors will not see any participant's map or hear anything from me about what has been talked about in the research interviews. Further, I will not hear anything from the person's counsellor about what they have discussed in their counselling sessions. Participants are, however, welcome to talk about their experience of being part of the research project with their counsellor if they wish.

Participation in the first part of the project does not mean people have to participate at the end of their counselling. When a person finishes their counselling, I will contact them to confirm that they are still interested in taking part. People can also withdraw from the study at any stage by contacting me.

If you have any questions or concerns regarding the study, please contact me using the details below, or contact the research supervisor, John McLeod, at the Tayside Institute for Health Studies, University of Abertay Dundee, Dudhope Castle, Dundee DD3 6HF, e [REDACTED]
[REDACTED] Alternative, you can also contact the centre manager, [REDACTED] by phoning [REDACTED].

Brian Rodgers

c/- [REDACTED].

APPENDIX C: Contact Consent Form

A study is currently being undertaken at the Tom Allan Centre to explore the changes that people experience in their life from coming to counselling. This research is being conducted by Brian Rodgers as part of his PhD studies at the University of Abertay Dundee, under the supervision of Professor John McLeod. Further details of the study are available on the sheet titled "Life Space Mapping Project Information Sheet".

At this stage, Brian is looking for people who might be interested in participating in the study. This will involve being interviewed by Brian before counselling begins, again when counselling finishes, and finally about 3 months afterwards. Each interview will last approximately 1 hour and will be held at the Tom Allan Centre.

Your participation in this research would be greatly appreciated but is entirely voluntary. If you decide not to participate, this will not effect the counselling you receive in any way. If you do decide to participate, your counsellor will not be informed. No information will be passed to your counsellor by the researcher, and all details about your participation will be held in confidence. You are, however, welcome to discuss your participation in the research with your counsellor if you desire.

If you decide to participate now but change your mind at a later date, you can withdraw from the study at any time with no consequences to your ongoing counselling. Any details and interview material that have been collected so far for the study will be destroyed.

If you are interested in participating in the study, please provide your name and preferred contact details below, then sign and date the form and either hand it to the counsellor or the receptionist at the centre, or send it to Brian Rodgers, c/- [REDACTED]
[REDACTED] Brian will then contact you to arrange a suitable date and time for an initial interview.

Name: _____

I would prefer to be contacted by: (please provide one or more of the following)

Phone number: _____
Is it okay to leave a message: YES [] NO []

Email address: _____

Postal address: _____

I confirm that I have read the Life Space Mapping Project Information Sheet and give my consent for Brian to contact me regarding my participation in the study.

Signature: _____

Date: _____

APPENDIX D: Participant Consent Form

I consent to participate in the research project conducted by Brian Rodgers entitled “Life Space Mapping” under the supervision of Professor John McLeod from the Tayside Institute for Health Studies.

I realise the purpose of this project is to examine the experiences of individuals and not to evaluate the individual, the counsellor or the counselling service. I also realise that I may not gain any personal benefit from participating in the study.

I understand that participation in the study will involve being interviewed by Brian before I begin counselling, again at the end of counselling, and finally approximately three to six months following counselling. I also understand that these interviews will be audio recorded and transcribed for use in his research.

I understand that the results of this research will be coded in such a manner that my identity will not be attached physically to the information I contribute and will be accessible only to the researcher. All responses will be kept confidentially and will not be related to my counsellor.

I am aware that these results may be published or reported to scientific bodies but I will not be identified in any such publication or report. Further, I am aware that I can request for any specific details to be omitted, and to see the final report before it is submitted.

I understand that my participation is voluntary and that there is no penalty for refusal to participate. I am aware that I am free to withdraw my consent and discontinue participation at any time.

I confirm that I have read and understood the Life Space Mapping Project Information Sheet and hereby consent to participate in the study conducted by Brian Rodgers

Name: _____

Signature: _____ **Date:** _____

APPENDIX E: Post Participation Consent Form

I give permission for the interview transcripts and life space maps produced during my participation in the research project conducted by Brian Rodgers to be included in his PhD dissertation, and published or reported to scientific bodies (i.e. academic publications, scientific journals or research conferences) given the following terms and conditions: (please tick the relevant points)

- ☐ I do not want any of the material collected to be published.
- ☐ I am willing for copies of the life space maps to be published.
- ☐ I am willing for small segments (e.g. individual quotes) of the interview transcripts to be published.
- ☐ I am willing for all material that has been collected to be published, including detailed case study accounts.
- ☐ I require to see any material before it is published.
- ☐ I would like to see a copy of the final report after it is completed.

I understand that this material will also be read by the academic examiners of the PhD dissertation, the supervisor of the researcher, and other counselling researchers.

I understand that I will not be identified in any publication or report. My name, if used, will always be replaced by a pseudonym. In addition, I have clearly specified below any biographical and/or personal information that I want to be excluded or altered in the reports in order to protect my anonymity.

After completion of the research project, I would like all the material collected to be: (please tick the relevant point)

- ☐ Destroyed.
- ☐ Returned to me.
- ☐ Kept by the researcher.
- ☐ Made available for further research. (You may withdraw your permission for this at any stage by contacting the researcher.)

Name: _____

Signature: _____ **Date:** _____

APPENDIX F: Life Space Map Introduction

Everyone's life is different. Each person has a unique view of life, relationships and what is significant to them. The following exercise is intended to explore your view of your life as it is just now - your 'Life Space'. This includes your friends, family, partner, work colleagues etc, places such as home, university, school, work, the outdoors, etc, sporting activities, cultural activities, social engagements, religion, politics - whatever you feel is important in your life just now. You can also include memories of things, people who have left your life, or imaginary/fictional people or places if you wish.

Please include any things you are experiencing difficulty with just now, and pay particular attention to any areas of tension or conflict. What causes the tension? Are there conflicting needs/demands? What forces are around? What keeps the situation like this? Where is the tension/conflict greatest? What/where are the important boundaries, where one thing or area of your life space comes up against another one? Where are these boundaries stretched the most?

Please also try to indicate on your map where you feel your life is heading. Are you moving towards or away from certain things? Do you feel pushed or pulled in different directions? You may find it useful to use arrows to indicate this on your map.

Please use whatever words, lines, pictures and colours you want to represent your life space. There are a variety pencils, pens, crayons etc which you can use to write or draw with. Feel free to use another piece of paper to expand any areas you would like to explore in more detail.

To start with, it may help to choose one thing that is significant in your life just now and to put this down on the paper first. Then, start adding other things to this one by one, and show how they connect to each other.

Feel free to ask any questions as you go, and to discuss with me what you are doing. Remember, the aim is to make something that is meaningful to you, not to make a 'good' picture, so please feel free to experiment with what works for you.

Once again, thank you for your participation.

Brian Rodgers.

Appendix G

Appendix G (pp.282-283) the **CORE-OM Questionnaire** has been removed from the e-thesis due to copyright restrictions.

APPENDIX H: CORE-OM Mean Scores

Pre-therapy CORE-OM data

Client ID	Wellbeing	Problems	Functioning	Risk	All minus Risk	All
001	10.00	8.33	16.67	0.00	12.14	10.00
002	30.00	30.83	25.00	3.33	28.21	23.82
003	25.00	27.50	25.83	8.33	26.43	23.24
004	17.50	16.67	20.00	3.33	18.21	15.59
005	25.00	32.50	21.67	6.67	26.79	23.24
006	22.50	26.67	12.50	0.00	20.00	16.47
007	35.00	35.00	30.83	26.67	33.21	32.06
008	17.50	20.00	16.67	3.33	18.21	15.59
009	30.00	29.17	21.67	5.00	26.07	22.35
010	27.50	15.00	16.67	1.67	17.50	14.71
011	12.50	10.00	10.83	0.00	10.71	8.82
012	35.00	32.50	27.50	10.00	30.71	27.06
013	32.50	37.50	25.83	16.67	31.79	29.12
014	35.00	34.17	33.33	8.33	33.93	29.41
015	25.00	32.50	20.00	11.67	26.07	23.53
016	20.00	13.33	16.67	1.67	15.71	13.24
017	0.00	14.17	12.50	10.00	11.43	11.18
018	27.50	26.67	25.00	10.00	26.07	23.24
019	30.00	25.00	24.17	11.67	25.36	22.94
020	7.50	17.27	12.50	5.00	13.70	12.12
021	15.00	16.67	10.00	0.00	13.57	11.18
022	22.50	9.17	18.33	1.67	15.00	12.65
023	35.00	32.00	18.33	0.00	26.15	21.25
024	2.50	9.17	8.33	0.00	7.86	6.47
025	30.00	30.00	20.83	0.00	26.07	21.47
026	17.50	12.73	20.91	13.33	16.92	16.25
027	32.50	26.67	26.67	13.33	27.50	25.00
028	25.00	25.00	18.33	1.67	22.14	18.53
029	25.00	19.17	16.67	8.33	18.93	17.06
030	12.50	20.83	9.17	0.00	14.64	12.06
031	17.50	19.17	13.33	3.33	16.43	14.12
032	27.50	24.17	24.17	3.33	24.64	20.88
033	30.00	35.83	22.50	18.33	29.29	27.35
034	37.50	30.00	33.64	26.67	32.69	31.56
035	12.50	11.67	2.73	0.00	8.15	6.67
036	17.50	21.67	20.83	0.00	20.71	17.06
037	15.00	6.67	10.83	5.00	9.64	8.82
038	30.00	24.17	28.33	3.33	26.79	22.65
039	17.50	16.36	19.17	3.33	17.78	15.15
040	32.50	26.36	7.50	0.00	18.89	15.45
041	25.00	20.00	16.67	0.00	19.29	16.36
042	20.00	24.17	15.83	0.00	20.00	16.47
043	30.00	29.17	23.33	13.33	26.79	24.41

Post-therapy CORE-OM data

Client ID	Wellbeing	Problems	Functioning	Risk	All minus Risk	All
001	0.00	6.67	3.64	1.67	4.44	3.94
002	15.00	15.00	8.33	0.00	12.14	10.00
003	27.50	21.67	25.00	11.67	23.93	21.76
006	7.50	7.50	12.50	0.00	9.64	7.94
008	15.00	10.00	9.17	1.67	10.36	8.82
014	30.00	22.50	30.00	0.00	26.79	22.06
017	2.50	7.50	10.00	8.33	7.86	7.94
019	12.50	16.67	15.00	6.67	15.36	13.82
020	0.00	1.67	0.83	0.00	1.07	0.88
021	0.00	5.00	0.83	0.00	2.50	2.06
032	12.50	11.67	10.00	0.00	11.07	9.12
033	12.50	12.50	6.67	5.00	10.00	9.12
037	10.00	1.67	3.33	0.00	3.57	2.94
038	25.00	26.67	20.83	0.00	23.93	19.71
040	5.00	8.33	3.64	0.00	5.93	4.85
041	12.50	8.33	12.50	0.00	10.71	8.82
043	35.00	34.17	27.50	20.00	31.43	29.41

Follow up CORE-OM data

Client ID	Wellbeing	Problems	Functioning	Risk	All minus Risk	All
001	0.00	3.33	0.83	0.00	1.79	1.47
002	17.50	27.00	8.33	0.00	16.92	13.75
008	17.50	10.00	12.73	3.33	12.22	10.61
014	25.00	20.00	21.67	3.33	21.43	18.24
017	7.50	15.00	10.83	5.00	12.14	10.88
019	10.00	10.00	11.67	3.33	10.71	9.41
021	2.50	4.17	1.67	0.00	2.86	2.35
032	7.50	10.83	5.00	1.67	7.86	6.76
037	0.00	5.00	2.50	1.67	3.21	2.94

APPENDIX H: Scoring Scheme for Qualitative Thematic Analysis

Adapted from Rodgers, B & Cooper, M (2006) *Proposed Scoring Scheme for Qualitative Thematic Analysis*. Available from http://www.strath.ac.uk/media/departments/eps/counsellingunit/Proposed_Scoring_Scheme_for_Qualitative_Thematic_Analysis.doc.

Drawing on the work of psychotherapy researchers Robert Elliott, Clara Hill and colleagues, the following scheme has been proposed for the write up of qualitative thematic analysis when describing the ‘weighting’ of codes or categories (i.e. the number of interviews that the code/category appeared in). The intention is to use ‘plain English’ terms to describe the frequency of occurrence. For example the term ‘around half’ is used to describe 50% plus or minus one interview, and ‘nearly all’ is used to describe 100% minus one or two interviews.

The table below sets out the proposed scoring scheme for studies with various numbers of participants, from 6 to 20. It is not envisaged that this scheme is applicable to studies of less than 6 participants, however the scheme could well be extended beyond 20. The scoring tends to be pessimistic, such that ‘Around half’ equates to a half and slightly more rather than a half and slightly less. Additionally, the ‘Nearly all’ is restricted to All-1 until there are more than 11 participants in a study.

Term =>	One	A couple	Some	Around Half	Most	Nearly All	All
Number of participants in study	Frequency of occurrence						
	1	2	3 to 50%-1or2	50% (±1)	50%+1or2 to 100% - 1,2or3	100% - 1or2	All
6	1	2		3	4	5	6
7	1	2	3	4	5	6	7
8	1	2	3	4	5-6	7	8
9	1	2	3	4-5	6-7	8	9
10	1	2	3-4	5-6	7-8	9	10
11	1	2	3-4	5-6	7-9	10	11
12	1	2	3-5	6-7	8-9	10-11	12
13	1	2	3-5	6-7	8-10	11-12	13
14	1	2	3-6	7-8	9-11	12-13	14
15	1	2	3-6	7-8	9-12	13-14	15
16	1	2	3-7	8-9	10-13	14-15	16
17	1	2	3-7	8-9	10-14	15-16	17
18	1	2	3-8	9-10	11-15	16-17	18
19	1	2	3-8	9-10	11-16	17-18	19
20	1	2	3-9	10-11	12-17	18-19	20

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Redacted pages: pp.287-292

Rodgers, B. (2006) 'Life space mapping: Preliminary results from the development of a new method for investigating counselling outcomes', *Counselling and Psychotherapy Research*, 6(4), pp. 227-232. doi: 10.1080/14733140601045437.